

2012 NOV 9 AM 10 54

**CERTIFICATE OF NEED APPLICATION**

**For the**

**INITIATION OF SWING BED SERVICES AT  
JAMESTOWN REGIONAL MEDICAL CENTER -  
JAMESTOWN, TN**

**November 12, 2012**

**Contact:  
Melanie B. Robinson**

**Health Management Associates / Tennova Healthcare  
200 E. Blount Avenue, Suite 600  
Knoxville, TN 37920**

**SECTION A:**

2012 NOV 9 AM 10 54

**APPLICANT PROFILE**

<b>1. <u>Name of Facility, Agency, or Institution</u></b>			
<b>HMA Fentress County General Hospital, LLC, d/b/a Jamestown Regional Medical Center</b>			
Name			
<b>436 Central Avenue West</b>		<b>Fentress</b>	
Street or Route		County	
<b>Jamestown</b>	<b>TN</b>	<b>38556</b>	
City	State	Zip Code	
<b>2. <u>Contact Person Available for Responses to Questions</u></b>			
<b>Melanie B. Robinson</b>		<b>Director of Business Development</b>	
Name		Title	
<b>Health Management Associates</b>		<b>Melanie.robinson@hma.com</b>	
Company Name		Email address	
<b>200 E. Blount Avenue, Suite 600</b>	<b>Knoxville</b>	<b>TN</b>	<b>37920</b>
Street or Route	City	State	Zip Code
<b>Employee</b>	<b>865-632-5604</b>	<b>865-632-5630</b>	
Association with Owner	Phone Number	Fax Number	
<b>3. <u>Owner of the Facility, Agency or Institution</u></b>			
<b>HMA Fentress County General Hospital, d/b/a Jamestown Regional Medical Center</b>			<b>931-752-5762</b>
Name			Phone Number
<b>436 Central Avenue West</b>		<b>Fentress</b>	
Street or Route		County	
<b>Jamestown</b>	<b>TN</b>	<b>38556</b>	
City	State	Zip Code	
<b>4. <u>Type of Ownership of Control (Check One)</u></b>			
A.	Sole Proprietorship		
B.	Partnership	F.	Government (State of TN or Political Subdivision)
C.	Limited Partnership	G.	Joint Venture
D.	Corporation (For Profit)	H.	Limited Liability Company
E.	Corporation (Not-for-Profit)	I.	Other (Specify) _____

**PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND  
REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.**

<b>5. Name of Management/Operating Entity (If Applicable)</b>				
<b>Not Applicable</b>				
Name			Phone Number	
Street or Route			County	
City		State	Zip Code	
<b>PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.</b>				
<b>6. Legal Interest in the Site of the Institution (Check One)</b>				
A.	Ownership	<input checked="" type="checkbox"/>	D.	Option to Lease
B.	Option to Purchase		E.	Other (Specify) _____
C.	Lease of _____ Years			
<b>PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.</b>				
<b>7. Type of Institution (Check as appropriate--more than one response may apply)</b>				
A.	Hospital (Specify) <u>General</u>	<input checked="" type="checkbox"/>	I.	Nursing Home
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty		J.	Outpatient Diagnostic Center
C.	ASTC, Single Specialty		K.	Recuperation Center
D.	Home Health Agency		L.	Rehabilitation Facility
E.	Hospice		M.	Residential Hospice
F.	Mental Health Hospital		N.	Non-Residential Methadone Facility
G.	Mental Health Residential Treatment Facility		O.	Birthing Center
H.	Mental Retardation Institutional Habilitation Facility (ICF/MR)		P.	Other Outpatient Facility (Specify) _____
			Q.	Other (Specify) _____
<b>8. Purpose of Review (Check) as appropriate--more than one response may apply)</b>				
A.	New Institution		G.	Change in Bed Complement
B.	Replacement/Existing Facility			
C.	Modification/Existing Facility			
D.	Initiation of Health Care Service as defined in TCA §68-11-1607(4) (Specify) <u>Swing Beds</u>	<input checked="" type="checkbox"/>	H.	Change of Location
E.	Discontinuance of OB Services		I.	Other (Specify) _____
F.	Acquisition of Equipment			

**9. Bed Complement Data***Please indicate current and proposed distribution and certification of facility beds.*

		<i>Current Beds</i> <i>Licensed      *CON</i>		<i>Staffed</i> <i>Beds</i>	<i>Beds</i> <i>Proposed</i>	<i>TOTAL</i> <i>Beds at</i> <i>Completion</i>
A.	Medical	75		54	-6	69
B.	Surgical					
C.	Long-Term Care Hospital					
D.	Obstetrical					
E.	ICU/CCU					
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric	10		10		10
J.	Child/Adolescent Psychiatric					
K.	Rehabilitation					
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds				6	6
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	<b>TOTAL</b> *CON-Beds approved but not yet in service	85		64	0	85

10. Medicare Provider Number <u>44-0083</u> Certification Type _____
11. Medicaid Provider Number <u>44-0083</u> Certification Type _____
12. If this is a new facility, will certification be sought for Medicare and/or Medicaid?  Not applicable.
13. Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area. Will this project involve the

treatment of TennCare participants? Yes If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted or plans to contract.

Jamestown Regional Medical Center has contracted with Americhoice, Amerigroup, Bluecare, and TennCare Select.

**Discuss any out-of-network relationships in place with MCOs/BHOs in the area.**

Not applicable.

**NOTE:** **Section B** is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. **Section C** addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. **Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.**

#### **SECTION B: PROJECT DESCRIPTION**

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

**I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.**

##### Project Description

HMA Fentress County General Hospital, LLC, d/b/a Jamestown Regional Medical Center ("Jamestown RMC") is an 85-bed acute care hospital, currently licensed for 75 Medical/Surgical beds and ten (10) Geriatric Psychiatric beds. Jamestown RMC is the only hospital providing acute care services in Fentress County. In this application, Jamestown RMC proposes to initiate Swing Bed Services by converting six acute care beds to skilled nursing/swing beds, in order to maximize the efficiency of operations and meet the unpredictable demands for acute or skilled level beds. No other health care services will be initiated or discontinued.

Under the Affordable Care Act, there is a growing emphasis by all payers, particularly Medicare and Medicaid, for patients to receive care in the most appropriate setting for their needs, which has increased the demand for enhanced discharge planning, case management, and enhanced resources for patients who continue to need care following an acute-care hospital stay.

##### Services and Equipment

The proposed swing beds will be located within the existing nursing units. Additional services provided for the patients will include physical, occupational and speech

therapies. No construction is required for the project, although some minor equipment for physical therapy is required. The list of equipment to be purchased is Attachment B.I.Project Description.1. Skilled nursing will be provided by the existing hospital nursing staff.

#### Ownership Structure

Jamestown Regional Medical Center is owned and operated by HMA Fentress County General Hospital, LLC, which is a wholly owned subsidiary of Health Management Associates, LLC, of Naples, Florida. The ownership structure is shown on the organizational chart, Attachment B.I.Project Description.2. Health Management operates 70 hospitals in 15 states. Besides Jamestown RMC, Health Management also operates University Medical Center in Lebanon, Harton Regional Medical Center in Tullahoma, and the six Tennova Healthcare hospitals in Knox, Jefferson, Campbell, and Cocke counties in Tennessee.

The swing beds proposed in this application will be owned solely by Jamestown RMC and operated under its hospital license.

#### Service Area

The service area is a six county area, consisting of Fentress, Pickett, Morgan, Scott, Putnam, and Cumberland counties, which are the source for 95% of Jamestown RMC's inpatient admissions. A map of the proposed service area is attached, as Attachment B.I.Project Description.3.

#### Need

Utilizing the population-based calculation outlined by the State for determining the need for nursing home/skilled beds, the six county service area for the project has a current need for 1,633 beds. In the six counties, there are 1,330 existing beds, with no further approved, unimplemented beds, leaving a deficit of 303 beds, based on the population-based demand calculation. Projecting two years forward, to 2014, the bed deficit grows to 390 beds for the service area. The demand calculation can be seen on Attachment B.I.Project Description.4.

In 2011, Jamestown RMC discharged 338 patients, or 14.6% of total discharges, from acute care into a skilled bed in another facility. As a convenience for patients and their families, converting six acute care beds to swing beds would allow a portion of those patients to stay in a familiar environment, avoid transfer to another facility, and yet be cared for in the appropriate setting for their acuity. With six beds available as swing beds, the available capacity would be 2,190 patient days of care. The average length of stay for skilled nursing beds in the service area is 55 days. At 55 days average length of stay, Jamestown RMC's swing beds could serve a maximum of 39 patients, or 11.5% of its current discharges into skilled beds, ensuring that a minimum of 299 patients annually continue to utilize other skilled beds in the service area.

#### Existing Resources

There are twelve skilled nursing facilities/nursing homes in the six county service area, with a total of 1,330 beds. In every case, the other Providers are serving both patients

	<p>who need skilled nursing, as well as those who don't require skilled nursing but need intermediate (Level I) care. Those providers are averaging 85.5% occupancy serving both patient populations. For a detailed listing of the Providers in the service area, see Attachment B.I.Project Description.5.</p> <p><u>Project Cost and Funding</u></p> <p>The only costs for the project are the purchase of minor therapy equipment, attorney fees, and the CON application filing fee, for a total of \$30,677.00. A list of therapy equipment that will be purchased is attached as Attachment B.I.Project Description.6. The project will be funded through the operating profit of the hospital.</p> <p><u>Financial Feasibility</u></p> <p>The project is projected is financially feasible, with an estimated operating profit of \$101,182 in the first year.</p> <p><u>Staffing</u></p> <p>Because the swing beds are integrated with the hospital's nursing units, staffing for the project is already in place. During the first year of operation, expected staffing levels for these units is 13.5 FTE's, 1.0 nurse manager, 4.0 registered nurses, 4.0 licensed professional nurses, 3.0 nurse aides, 1.0 case manager, and 0.5 social worker. The Medical Director for the swing beds will be Dr. Jonathon Allred, who is currently a member of the Jamestown RMC Medical Staff. Dr. Allred's CV is attached as Attachment B.I.Project Description.7. Upon approval of this application, the hospital will recruit and employ a part-time therapist to provide physical and occupational therapy.</p>
<b>II.</b>	<b>Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.</b>
<b>A.</b>	<p><b>Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of \$5 million) and other facility projects (construction cost in excess of \$2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.</b></p> <p><b>If the project involves none of the above, describe the development of the</b></p>

		<p><b>proposal.</b></p> <p>Not applicable.</p>
	<b>B.</b>	<p><b>Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.</b></p> <p>The total number of licensed beds operated by Jamestown RMC will not change as a result of this application, but six (6) of the existing acute care beds will be converted to swing beds. As a facility serving a rural community, the approval of the conversion of acute care beds to swing beds will support the hospital's ability to provide more convenient access to post-acute care for patients who qualify for it, as well as to enhance the hospital's ability to maximize operational efficiency by broadening its ability to utilize licensed and staffed beds.</p> <p>Approval of this application will broaden the hospital's ability to provide physical and occupational therapy to its patients, by supporting the employment of a therapist.</p>



		<b>C.</b>	<p><b>As the applicant, describe your need to provide the following health care services (if applicable to this application):</b></p> <ol style="list-style-type: none"> <li><b>1. Adult Psychiatric Services</b></li> <li><b>2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)</b></li> <li><b>3. Birthing Center</b></li> <li><b>4. Burn Units</b></li> <li><b>5. Cardiac Catheterization Services</b></li> <li><b>6. Child and Adolescent Psychiatric Services</b></li> <li><b>7. Extracorporeal Lithotripsy</b></li> <li><b>8. Home Health Services</b></li> <li><b>9. Hospice Services</b></li> <li><b>10. Residential Hospice</b></li> <li><b>11. ICF/MR Services</b></li> <li><b>12. Long-term Care Services</b></li> <li><b>13. Magnetic Resonance Imaging (MRI)</b></li> <li><b>14. Mental Health Residential Treatment</b></li> <li><b>15. Neonatal Intensive Care Unit</b></li> <li><b>16. Non-Residential Methadone Treatment Centers</b></li> <li><b>17. Open Heart Surgery</b></li> <li><b>18. Positron Emission Tomography</b></li> <li><b>19. Radiation Therapy/Linear Accelerator</b></li> <li><b>20. Rehabilitation Services</b></li> <li><b>21. <u>Swing Beds</u></b></li> </ol> <p>As a rural hospital, Jamestown RMC needs the ability to provide the broadest possible range of services to the community as close to home as possible. Particularly for elderly patients with family living nearby, continuing care in the same location following an acute hospital stay to continue therapy or regain strength is very convenient. Almost 15% of Jamestown RMC's discharges are discharged into another care setting; having the ability to serve a portion of that patient population improves convenience for those patients and increases the operational efficiency of the hospital.</p>	
		<b>D.</b>	<p><b>Describe the need to change location or replace an existing facility.</b></p> <p>Not applicable.</p>	
		<b>E.</b>	<p><b>Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of \$1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:</b></p>	
		<b>1.</b>	<b>For fixed-site major medical equipment (not replacing existing equipment):</b>	
		<b>a.</b>	<b>Describe the new equipment, including:</b>	
			<ol style="list-style-type: none"> <li><b>1. Total cost ;(As defined by Agency Rule).</b></li> <li><b>2. Expected useful life;</b></li> <li><b>3. List of clinical applications to be provided; and</b></li> </ol>	

				<b>4. Documentation of FDA approval.</b>  Not applicable.
			b.	<b>Provide current and proposed schedules of operations.</b>  Not applicable.
		2.		<b>For mobile major medical equipment:</b>
			a.	<b>List all sites that will be served;</b>  Not applicable.
			b.	<b>Provide current and/or proposed schedule of operations;</b>  Not applicable.
			c.	<b>Provide the lease or contract cost</b>  Not applicable.
			d.	<b>Provide the fair market value of the equipment; and</b>  Not applicable.
			e.	<b>List the owner for the equipment.</b>  Not applicable.
		3.		<b>Indicate applicant's legal interest in equipment (i.e., purchase, lease, etc.) In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.</b>  Not applicable.
III	(A)	<b>Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which must include:</b> <b>1. Size of site (in acres);</b> <b>2. Location of structure on the site; and</b> <b>3. Location of the proposed construction.</b> <b>4. Names of streets, roads or highway that cross or border the site.</b> <i>Please note that the drawings do not need to be drawn to scale.</i> <i>Plot plans are required for all projects.</i>  See attached plot plan for Jamestown RMC, Attachment B.III.(A). There is no construction proposed as part of this application.		
	(B)	<b>1. Describe the relationship of the site to public transportation routes, if</b>		

	<p><b>any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.</b></p> <p>Jamestown RMC is accessible via Highways 127, 154, and 52. While public transportation is not available in Fentress County, Upper Cumberland Transportation, a local van service, can assist patients with transportation if needed.</p>
<b>IV.</b>	<p><b>Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.</b></p> <p><b>NOTE: <u>DO NOT SUBMIT BLUEPRINTS</u>. Simple line drawings should be submitted and need not be drawn to scale.</b></p> <p>A floor plan of the nursing units is attached as Attachment B.IV.</p>
<b>V.</b>	<p><b>For a Home Health Agency or Hospice, identify:</b></p> <ol style="list-style-type: none"> <li><b>1. Existing service area by County;</b></li> <li><b>2. Proposed service area by County;</b></li> <li><b>3. A parent or primary service provider;</b></li> <li><b>4. Existing branches; and</b></li> <li><b>5. Proposed branches.</b></li> </ol> <p>Not applicable</p>

### **SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED**

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper.* All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

## QUESTIONS

### Need

1.	<p><b>Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.</b></p>
	<p><b>A. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.</b></p> <p>The Guidelines for Swing Bed Services are applicable to this application. The Guidelines for Growth for Nursing Home Services are also applicable, since the Swing Bed guidelines reference those guidelines. Both sets of guidelines are addressed in this application.</p> <p style="text-align: center;"><b><u>Nursing Home Services</u></b></p> <p><b>A. Need</b></p> <p><b>1. According to TCA 68-11-108, the need for nursing home beds shall be determined by applying the following population-based statistical methodology:</b></p> <p style="text-align: center;"> <b>County bed need= .0005 x pop. 65 and under, plus</b>  <b>.0120 x pop. 65-74, plus</b>  <b>.0600 x pop. 75-84, plus</b>  <b>.1500 x pop. 85 plus</b> </p> <p>The application meets the guideline, based on the calculation of population-based demand. The total population of the six county service area is 194,659. After breaking the population down into the age cohorts outlined in the County Bed Need calculation above and factoring in the bed need for each age cohort, the bed need for the six counties is calculated to be 1,633. There are currently 1,330 beds in service, leaving a deficit of 303 beds. For a detailed calculation of population-based demand versus current resources, see Attachment C.Need.A.1.</p> <p><b>2. The need for nursing home beds shall be projected two years into the future from the current year, as calculated by the Department of Health.</b></p> <p>In the six county service area, population growth is expected to be approximately 2.3%, based on Department of Health population statistics. Assuming that no additional skilled nursing beds are approved in the service area during that time, the deficit of needed beds versus available beds in the service area will have grown to 380 beds. For a detailed calculation of bed need and availability for 2012-2014 (projected), see Attachment C.Need.A.2.</p>

**3. The source of the current supply and utilization of licensed and CON approved nursing home beds shall be the inventory of nursing home beds maintained by the Department of Health.**

The skilled nursing bed counts utilized in this application were taken from the records of the Department of Health.

**4. "Service Area" shall mean the county or counties represented on an application as the reasonable area to which a health care institution intends to provide services and/or in which the majority of its service recipients reside. A majority of the population of a service area for any nursing home should reside within 30 minutes travel time from that facility.**

The service area proposed in this application is the six counties from which Jamestown Regional Medical Center derives 95% of its patients. Jamestown RMC is located in Fentress County; the other five counties in the service area are contiguous to Fentress County, and each of the counties in the service have areas that are within 30 minutes travel time to Jamestown RMC.

**5. The Health Facilities Commission may consider approving new nursing home beds in excess of the need standard for a service area, but the following criteria must be considered:**

**a. All outstanding CON projects in the proposed service area resulting in a net increase in beds are licensed and in operation, and**

All outstanding CON projects in the proposed service area resulting in a net increase in beds are licensed and in operation.

**b. All nursing homes that serve the same service area population as the applicant have an annualized occupancy in excess of 90%.**

The occupancy of nursing home beds in the service area was 85.5% at the end of 2011, which is the date of the most recently reported data. While this does not meet the guideline specifying that nursing homes serving the service area should have an annualized occupancy over 90%, there are other factors that should be considered.

Swing beds provide a different level of convenience for patients and their families by allowing the patient to stay in the same care environment while receiving less acute services. For a rural hospital working to expand the continuum of care it is able to offer the members of the community, having the flexibility to serve patients who no longer qualify for acute services but need care before going home enhances the patient experience as well as convenience for family members. The hospital will use the swing beds to serve patients who have completed an inpatient stay and need more care, as opposed to marketing the beds to the community, the way a nursing home must. Patients requiring

	<p>longer stays or intensive therapy services will be transferred to a nursing home in the service area.</p> <p>The swing beds will also support the hospital's ongoing viability, by enabling the applicant to more efficiently utilize the beds for which it is licensed.</p> <p><b>B. Occupancy and Size Standards:</b></p> <p><b>1. A nursing home should maintain an average annual occupancy rate for all licensed beds of at least 90 percent after two years of operation.</b></p> <p>Not applicable.</p> <p><b>2. There shall be no additional nursing home beds approved for a service area unless each existing facility with 50 beds or more has achieved an average annual occupancy rate of 95 percent. The circumstances of any nursing home, which has been identified by the Regional Administrator, as consistently noncomplying with quality assurance regulations shall be considered in determining the service areas, average occupancy rate.</b></p> <p>According to the 2011 Joint Annual Reports provided by the nursing homes in the service area, there is an average annual occupancy rate of 85.5% (see the utilization chart, Attachment C.Need.B.2). However, these are true nursing home beds in nursing home facilities, as opposed to swing beds in a rural hospital. A key part of the Affordable Care Act is the treatment of patients in the most appropriate care setting. There are no other hospitals in the service area offering swing beds for the convenience of patients who have already had an inpatient stay and might simply need a few more days of nursing care prior to returning home. The most efficient and convenient way to care for these patients is to allow them to complete their care in the same environment, without the stress of a short-term transfer to a nursing home. Patients requiring longer stays or intensive therapy services will be transferred to a nursing home in the service area.</p> <p><b>3. A nursing home seeking approval to expand its bed capacity must have maintained an occupancy rate of 95 percent for the previous year.</b></p> <p>Not applicable.</p> <p><b>4. A free-standing nursing home shall have a capacity of at least 30 beds in order to be approved. The health Facilities Commission may make an exception to this standard. A facility of less than 30 beds may be located in a sparsely populated rural area where the population is not sufficient to justify a larger facility. Also, a project may be developed in conjunction with a retirement center where only a limited number of beds are needed for the residents of that retirement center.</b></p> <p>Not applicable.</p>
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		<p style="text-align: center;"><b><u>Swing Bed Services</u></b></p> <p><b>A. Applicants must meet the same standards for determining need as applicants for nursing homes, with the exception of the standard for the minimum number of beds required for a freestanding nursing home.</b></p> <p>The Nursing Home Services guidelines have been addressed above.</p> <p><b>B. Applicants must meet appropriate federal criteria as mandated by the Health Care Financing Administration.</b></p> <p>The applicant meets appropriate federal criteria as mandated by the Health Care Financing Administration.</p> <p><b>C. Any existing provider must document that all deficiencies (if any) cited in the last licensure and/or certification inspection have been corrected.</b></p> <p>A copy of the most recent Joint Commission survey is attached, as Attachment C.Need.Swing Bed Services.C. All noted deficiencies have been corrected.</p>

	<p><b>B. Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c).</b></p> <p>Not applicable.</p>
2.	<p><b>Describe the relationship of this project to the applicant facility's long-range development plans, if any.</b></p> <p>As the only facility providing acute care hospital services in Fentress County, Jamestown Regional Medical Center is committed to the ongoing expansion of services to the region, most particularly the expansion of its ability to provide services across the continuum of care. The Affordable Care Act puts additional emphasis on providing care in the most appropriate setting, and the hospital's plans include continued development of services in a variety of settings, from outpatient services to acute care to long-term care services. This application, if approved, will allow the hospital to provide patients in this rural community with an option for skilled care that allows patients who are already in the hospital for an acute stay to remain there to receive the balance of the care they need before returning home. This project is a key part of the hospital's long-range development plans to expand services along the entire continuum of care.</p>
3.	<p><b>Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit the map on 8 1/2" x 11"</b></p>

	<p><b>sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).</b></p> <p>The project service area consists of six counties in Tennessee, Fentress, Morgan, Pickett, Scott, Putnam, and Cumberland. 95% of Jamestown Regional Medical Center's inpatient admissions originate from these six counties. A map of the service area is attached as Attachment C.Need.3.</p>																																																
4.	<p><b>A. Describe the demographics of the population to be served by this proposal.</b></p> <p>The population of the service area for this application is 194,659, and it is expected to grow by 3.9% between 2012 and 2016. See the table below.</p> <table border="1"> <thead> <tr> <th>County</th><th>2012</th><th>2016</th><th colspan="2">Growth 2012-2016</th></tr> </thead> <tbody> <tr> <td>Fentress</td><td>18,154</td><td>18,577</td><td>423</td><td>2.3%</td></tr> <tr> <td>Morgan</td><td>20,896</td><td>21,373</td><td>477</td><td>2.3%</td></tr> <tr> <td>Pickett</td><td>5,069</td><td>5,203</td><td>134</td><td>2.6%</td></tr> <tr> <td>Scott</td><td>23,253</td><td>24,086</td><td>833</td><td>3.6%</td></tr> <tr> <td>Putnam</td><td>72,489</td><td>75,364</td><td>2,875</td><td>4.0%</td></tr> <tr> <td>Cumberland</td><td>54,798</td><td>57,735</td><td>2,937</td><td>5.4%</td></tr> <tr> <td>Total</td><td>194,659</td><td>202,338</td><td>7,679</td><td>3.9%</td></tr> </tbody> </table> <p>Source: Division of Health Statistics, Tennessee Department of Health</p>	County	2012	2016	Growth 2012-2016		Fentress	18,154	18,577	423	2.3%	Morgan	20,896	21,373	477	2.3%	Pickett	5,069	5,203	134	2.6%	Scott	23,253	24,086	833	3.6%	Putnam	72,489	75,364	2,875	4.0%	Cumberland	54,798	57,735	2,937	5.4%	Total	194,659	202,338	7,679	3.9%								
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	<p><b>B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.</b></p> <p>A closer look at the population's makeup reveals that growth in the senior population (age 65+) continues to outpace growth of other age groups in both the service area and the state as a whole. Between 2012 and 2016, the senior population is expected to grow in the service area by 12.5%. The increase in the number of people in the 65+ group exceeds the increase in all other age groups. Growth in age groups under 65 is much lower, ranging from 0.8% to 1.7% over the same time period. See the table below.</p> <p><u>Percent Change in Population by Age Group 2012-2016</u></p> <table border="1"> <thead> <tr> <th>Growth Rate</th><th>0-19</th><th>20-44</th><th>45-64</th><th>65+</th><th>All Ages</th></tr> </thead> <tbody> <tr> <td>Fentress</td><td>0.6%</td><td>-1.1%</td><td>0.8%</td><td>13.3%</td><td>2.3%</td></tr> <tr> <td>Morgan</td><td>2.3%</td><td>1.2%</td><td>-1.6%</td><td>11.7%</td><td>2.3%</td></tr> <tr> <td>Pickett</td><td>4.3%</td><td>-0.4%</td><td>-1.8%</td><td>10.5%</td><td>2.6%</td></tr> <tr> <td>Scott</td><td>2.6%</td><td>0.5%</td><td>2.4%</td><td>14.8%</td><td>3.6%</td></tr> <tr> <td>Putnam</td><td>1.8%</td><td>1.8%</td><td>3.7%</td><td>13.0%</td><td>4.0%</td></tr> <tr> <td>Cumberland</td><td>0.8%</td><td>-0.1%</td><td>1.1%</td><td>11.9%</td><td>3.5%</td></tr> <tr> <td><b>Total Service Area</b></td><td><b>1.6%</b></td><td><b>0.8%</b></td><td><b>1.7%</b></td><td><b>12.5%</b></td><td><b>3.4%</b></td></tr> </tbody> </table>	Growth Rate	0-19	20-44	45-64	65+	All Ages	Fentress	0.6%	-1.1%	0.8%	13.3%	2.3%	Morgan	2.3%	1.2%	-1.6%	11.7%	2.3%	Pickett	4.3%	-0.4%	-1.8%	10.5%	2.6%	Scott	2.6%	0.5%	2.4%	14.8%	3.6%	Putnam	1.8%	1.8%	3.7%	13.0%	4.0%	Cumberland	0.8%	-0.1%	1.1%	11.9%	3.5%	<b>Total Service Area</b>	<b>1.6%</b>	<b>0.8%</b>	<b>1.7%</b>	<b>12.5%</b>	<b>3.4%</b>
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<b>Total Tennessee</b>	2.4%	1.5%	2.0%	12.4%	3.4%
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The rapid increase in the senior population supports the need for healthcare services geared toward the elderly, recognizing the unique needs of this population, particularly for services that provide care beyond acute care hospital stays.

#### Service Area Race-Ethnicity Make-up

There is a low degree of ethnic diversity in the service area, with 91% of the population classified as White Non-Hispanic. This compares to 74% statewide. See table below.

	<u>White</u>	<u>Black</u>	<u>Hispanic</u>	<u>Other</u>
Fentress	97.1%	0.2%	1.0%	1.7%
Morgan	93.6%	3.6%	0.8%	1.9%
Pickett	97.1%	0.1%	1.3%	1.5%
Scott	97.8%	0.1%	0.5%	1.6%
Putnam	87.3%	1.9%	5.1%	5.7%
Cumberland	90.3%	0.5%	4.1%	5.1%
<b>Total Service Area</b>	<b>91.3%</b>	<b>1.4%</b>	<b>3.3%</b>	<b>4.0%</b>
<b>Total Tennessee</b>	<b>74.2%</b>	<b>15.9%</b>	<b>4.4%</b>	<b>5.5%</b>

Source: US Census Data

#### Service Area Economic Indicators

Economically, the service area is more challenged than the state as a whole. Per capita income and median household incomes are well below the state average, and the percent of people in poverty is higher than the state average. See tables below.

	<u>Per Capita</u>	<u>Median</u>	<u>Persons Below</u>
	<u>Income</u>	<u>Household</u>	<u>Poverty Level</u>
	<u>Income</u>	<u>Income</u>	
Fentress	\$ 17,291	\$ 29,642	25.0%
Morgan	\$ 17,833	\$ 36,772	19.2%
Pickett	\$ 19,327	\$ 30,193	17.1%
Scott	\$ 15,087	\$ 28,728	24.5%
Putnam	\$ 19,434	\$ 35,185	22.5%
Cumberland	\$ 20,544	\$ 36,813	15.8%
<b>Total Service Area (ave.)</b>	<b>\$ 18,253</b>	<b>\$ 32,889</b>	<b>20.7%</b>
<b>Total Tennessee</b>	<b>\$ 23,722</b>	<b>\$ 43,314</b>	<b>16.5%</b>

Source: US Census Data

#### Insurance Coverage Estimates

Currently, it is estimated that about 42% of the service area population has commercial or private insurance, with another 22% utilizing Medicare and just under 16% on Medicaid/TennCare. The percentage of the population that is uninsured is high, at 19.6% versus a state average of 16.6%. Based on successful implementation of the recently enacted Affordable Care Act, the projections for 2015 suggest a drop in the numbers of uninsured by more than half, with the differences absorbed by Medicaid/TennCare, Medicare, and the new private Exchange. See table below.

	<u>2011</u>	<u>2015</u>
	<u>Est.</u>	<u>Est.</u>
Medicaid / TennCare	15.7%	22.6%
Medicare	17.0%	18.6%
Medicare - Dual Eligible	5.2%	5.5%
Private - Direct	4.3%	2.9%
Private - ESI	38.2%	37.0%
Private - Exchange	0.0%	6.7%
Uninsured	19.6%	6.6%

Source: Thomson Reuters – The Market Planner Plus

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

There are 1,330 nursing home beds in the service area, and no hospitals with swing beds. See the following table, which details the bed count and 2011 utilization for each institution.

Facility	Licensed Beds	Maximum Patient Days	Actual Patient Days	% Capacity
Signature Healthcare of Fentress County	140	51,100	35,385	69.2%
Pickett Care and Rehabilitation Center	69	25,185	23,631	93.8%
Life Care Center of Morgan County	124	45,260	34,978	77.3%
Huntsville Manor	96	35,040	32,661	93.2%
Oneida Nursing & Rehab Center	56	20,440	18,690	91.4%
Bethesda Health Care Center	120	43,800	40,560	92.6%
Masters Health Care Center	175	63,875	60,331	94.5%
NHC Healthcare, Cookeville	94	34,310	31,823	92.8%
Standing Stone Care & Rehabilitation Center	115	41,975	33,724	80.3%
Life Care Center of Crossville	122	44,530	31,127	69.9%
Mary Cravath Wharton Nursing Home	62	22,630	22,241	98.3%
WyndRidge Health & Rehabilitation Center	157	57,305	49,980	87.2%
All Providers*	1,330	485,450	415,131	85.5%

Source: 2011 Joint Annual Reports

6. **Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.**

Since swing beds will not be a new service, no information is available on utilization of the service for the past three years. Jamestown RMC is licensed for 85 beds, 75 medical/surgical beds and ten (10) gero-psychiatric beds. The hospital has run an average daily census of 49 over the past three years.

Projected utilization of the six proposed swing beds is based on the percentage of discharges currently requiring a post-discharge into acute care, and the percentage of those patients who could appropriately be cared for in a swing bed. In 2011, Jamestown RMC discharged a total of 2,314 patients. 14.6%, or 338 of those patients were discharged into a skilled bed within another facility. While in many cases a transfer to a nursing home is the most appropriate choice for patients and their families, for those patients requiring a shorter skilled stay or less intense therapy or rehabilitation services, avoiding a transfer to a new environment and staying in the hospital in a swing bed is the most convenient and comfortable choice.

The average length of stay for patients in skilled beds in the service area, as reported

	<p>in the 2011 Joint Annual Reports submitted by the service area nursing homes, was 55 days. Assuming that patients who would be a fit for the swing beds as opposed to a lengthy nursing home stay represent only a portion of the total discharges from the hospital, it is reasonable to assume that only 25% of the patients discharged into skilled beds from Jamestown RMC would appropriately stay in a swing bed. If 25% of the 338 patients, or 85 patients annually, were able to receive their needed skilled nursing within Jamestown RMC, and their average length of stay were half that of a typical nursing home patient, or 23 days, the average daily census in the swing beds would be 5.3, essentially fully utilizing the six beds annually.</p> <p>The utilization and financial projections are based on the assumption that the average daily census of the unit will be 5.3 and that the average length of stay for those patients will be 23 days, or half of the average length of stay for nursing home patients requiring longer term care or more therapy services than the hospital can offer.</p>
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## ECONOMIC FEASIBILITY

I.	<p><b>Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.</b></p>
	<ul style="list-style-type: none"> <li><b>All projects should have a project cost of at least \$3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)</b></li> </ul> <p>The minimum CON filing fee of \$3,000 has been inserted in the Project Cost Chart.</p>
	<ul style="list-style-type: none"> <li><b>The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.</b></li> </ul> <p>Not applicable.</p>
	<ul style="list-style-type: none"> <li><b>The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.</b></li> </ul> <p>The only equipment included in the project is minor equipment, which does not require installation or maintenance.</p>

	<ul style="list-style-type: none"> <li>• <b>For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.</b></li> </ul> <p>Not applicable.</p>
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# PROJECT COSTS CHART

2012 NOV 9 AM 10 54

A.	Construction and equipment acquired by purchase:		
	1.	Architectural and Engineering Fees	
	2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	\$25,000.00
	3.	Acquisition of Site	
	4.	Preparation of Site	
	5.	Construction Costs	
	6.	Contingency Fund	
	7.	Fixed Equipment (Not included in Construction Contract)	
	8.	Moveable Equipment (List all equipment over \$50,000)	\$2,677.00
	9.	Other (Specify) _____	

B.	Acquisition by gift, donation, or lease:		
	1.	Facility (inclusive of building and land)	
	2.	Building only	
	3.	Land only	
	4.	Equipment (Specify) _____	
	5.	Other (Specify) _____	

C.	Financing Costs and Fees:		
	1.	Interim Financing	
	2.	Underwriting Costs	
	3.	Reserve for One Year's Debt Service	
	4.	Other (Specify) _____	

D.	Estimated Project Cost (A+B+C)	\$27,677.00
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E.	CON Filing Fee	\$3,000.00
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F.	Total Estimated Project Cost (D+E)	\$30,677.00
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	TOTAL	\$30,677.00
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2.	<b>Identify the funding sources for this project.</b>  Please check the applicable item(s) below and briefly summarize how the project will be financed. <i>(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)</i>	
—	A.	<b>Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;charges.</b>
—	B.	<b>Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;</b>
—	C.	<b>General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.</b>
—	D.	<b>Grants--Notification of intent form for grant application or notice of grant award; or</b>
<u>X</u>	E.	<b>Cash Reserves--Appropriate documentation from Chief Financial Officer.</b>  A letter from the CFO is attached, Attachment C.Economic Feasibility.2.E.
—	F.	<b>Other—Identify and document funding from all other sources.</b>
3.	<b>Discuss and document the reasonableness of the proposed project costs. If applicable,compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.</b>  The project's only costs are minor equipment for physical therapy, attorney fees, and the CON filing fee. There is no construction involved in the project.	
4.	<b>Complete Historical and Projected Data Charts on the following two pages--Do not modify the Charts provided or submit Chart substitutions! Historical Data Chart represents revenue and expense information for the last <i>three (3)</i> years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the <i>Proposal Only</i> (i.e., if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).</b>  The Historical and Projected Data Charts are complete.	
5.	<b>Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.</b>  Projected gross charges per patient day are \$2,573.75. The average deduction from operating revenue assumed is 70%, for an average net charge of \$614.49. These assumptions are based on RUG/Reimbursement rates from the Medicare Federal Rate Tables.	

# **HISTORICAL DATA CHART**

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

	<u>Year 2009</u>	<u>Year 2010</u>	<u>Year 2011</u>
A. Utilization Data (Admissions)	<u>2,487</u>	<u>2,307</u>	<u>2,289</u>
B. Revenue from Services to Patients			
1. Inpatient Services	<u>\$35,802,115</u>	<u>\$36,741,393</u>	<u>\$36,922,288</u>
2. Outpatient Services	<u>39,226,632</u>	<u>38,481,703</u>	<u>43,080,887</u>
3. Emergency Services	<u>          </u>	<u>          </u>	<u>          </u>
4. Other Operating Revenue (Specify) <u>Cafeteria, Medical</u>	<u>53,003</u>	<u>42,433</u>	<u>50,269</u>
<u>Record Fees, Nursing Student Fees</u>			
<b>Gross Operating Revenue</b>	<b><u>\$75,081,750</u></b>	<b><u>\$75,265,529</u></b>	<b><u>\$80,053,444</u></b>
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	<u>\$46,356,633</u>	<u>\$47,140,334</u>	<u>\$49,311,303</u>
2. Provision for Charity Care	<u>7,845,263</u>	<u>8,314,376</u>	<u>9,596,874</u>
3. Provisions for Bad Debt	<u>2,914,185</u>	<u>2,550,841</u>	<u>2,832,644</u>
<b>Total Deductions</b>	<b><u>\$57,116,081</u></b>	<b><u>\$58,005,551</u></b>	<b><u>\$61,740,821</u></b>
<b>NET OPERATING REVENUE</b>	<b><u>\$17,965,669</u></b>	<b><u>\$17,259,978</u></b>	<b><u>\$18,312,623</u></b>
D. Operating Expenses			
1. Salaries and Wages	<u>\$10,039,123</u>	<u>\$9,601,915</u>	<u>\$8,996,114</u>
2. Physician's Salaries and Wages	<u>          </u>	<u>          </u>	<u>          </u>
3. Supplies	<u>1,918,924</u>	<u>1,763,487</u>	<u>1,665,688</u>
4. Taxes	<u>          </u>	<u>          </u>	<u>          </u>
5. Depreciation	<u>1,170,174</u>	<u>1,151,471</u>	<u>1,004,863</u>
6. Rent	<u>271,963</u>	<u>361,715</u>	<u>376,482</u>
7. Interest, other than Capital	<u>46,601</u>	<u>48,663</u>	<u>53,152</u>
8. Management Fees:			
a. Fees to Affiliates	<u>          </u>	<u>          </u>	<u>          </u>
b. Fees to Non-Affiliates	<u>          </u>	<u>          </u>	<u>          </u>
9. Other Expenses – Specify on separate page 14	<u>5,157,418</u>	<u>6,011,401</u>	<u>7,508,379</u>
<b>Total Operating Expenses</b>	<b><u>\$18,604,203</u></b>	<b><u>\$18,938,652</u></b>	<b><u>\$19,604,678</u></b>
E. Other Revenue (Expenses) – Net (Specify) <u>          </u>	<u>\$          </u>	<u>\$          </u>	<u>\$          </u>
<b>NET OPERATING INCOME (LOSS)</b>	<b><u>\$(638,534)</u></b>	<b><u>\$(1,678,674)</u></b>	<b><u>\$(1,292,055)</u></b>
F. Capital Expenditures			
1. Retirement of Principal	<u>\$          </u>	<u>\$          </u>	<u>\$          </u>
2. Interest	<u>          </u>	<u>          </u>	<u>          </u>
<b>Total Capital Expenditures</b>	<b><u>\$          </u></b>	<b><u>\$          </u></b>	<b><u>\$          </u></b>
<b>NET OPERATING INCOME (LOSS)</b>			
<b>LESS CAPITAL EXPENDITURES</b>	<b><u>\$(638,534)</u></b>	<b><u>\$(1,678,674)</u></b>	<b><u>\$(1,292,055)</u></b>

**D.9 Other Expenses:**

Other Operating Expenses include Repairs and Maintenance, Travel, Training, Meals, Dues and Subscriptions, Memberships, Recruitment.

	<u>2009</u>	<u>2010</u>	<u>2011</u>
Other Expenses	\$2,344,824	\$2,865,881	\$3,597,109
Outside Services	\$1,815,605	\$2,514,067	\$2,881,626
Corporate Allocation	<u>\$ 996,989</u>	<u>\$ 630,953</u>	<u>\$1,292,053</u>
<b>Total Other Expenses (D.9)</b>	<b>\$5,157,418</b>	<b>\$6,011,401</b>	<b>\$7,508,379</b>

### PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

	Year 1	Year 2
A. Utilization Data (Patient Days)	<u>1,984</u>	<u>2,076</u>
B. Revenue from Services to Patients		
1. Inpatient Services	<u>\$5,106,320</u>	<u>\$5,343,105</u>
2. Outpatient Services	<u>                    </u>	<u>                    </u>
3. Emergency Services	<u>                    </u>	<u>                    </u>
4. Other Operating Revenue (Specify) <u>                                    </u>	<u>                    </u>	<u>                    </u>
<b>Gross Operating Revenue</b>	<b><u>\$5,106,320</u></b>	<b><u>\$5,343,105</u></b>
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	<u>\$3,574,424</u>	<u>\$3,740,174</u>
2. Provision for Charity Care	<u>6,369</u>	<u>6,664</u>
3. Provisions for Bad Debt	<u>306,379</u>	<u>320,586</u>
<b>Total Deductions</b>	<b><u>\$3,887,172</u></b>	<b><u>\$4,067,424</u></b>
<b>NET OPERATING REVENUE</b>	<b><u>\$1,219,148</u></b>	<b><u>\$1,275,681</u></b>
D. Operating Expenses		
1. Salaries and Wages	<u>\$ 753,650</u>	<u>\$ 799,836</u>
2. Physician's Salaries and Wages	<u>20,000</u>	<u>20,000</u>
3. Supplies	<u>98,439</u>	<u>103,426</u>
4. Taxes	<u>27,980</u>	<u>29,318</u>
5. Depreciation	<u>60,292</u>	<u>60,292</u>
6. Rent	<u>23,808</u>	<u>24,912</u>
7. Interest, other than Capital	<u>                    </u>	<u>                    </u>
8. Management Fees:		
a. Fees to Affiliates	<u>                    </u>	<u>                    </u>
b. Fees to Non-Affiliates	<u>                    </u>	<u>                    </u>
9. Other Expenses -- Specify on separate page 14	<u>103,120</u>	<u>107,260</u>
<b>Total Operating Expenses</b>	<b><u>\$1,087,289</u></b>	<b><u>\$1,145,044</u></b>
E. Other Revenue (Expenses) -- Net (Specify) <u>                                    </u>	<u>\$</u>	<u>\$</u>
<b>NET OPERATING INCOME (LOSS)</b>	<b><u>\$ 131,859</u></b>	<b><u>\$ 130,637</u></b>
F. Capital Expenditures		
1. Retirement of Principal	<u>\$ 30,677</u>	<u>\$</u>
2. Interest	<u>                    </u>	<u>                    </u>

	Total Capital Expenditures	\$ <u>30,677</u>	\$ _____
NET OPERATING INCOME (LOSS)			
LESS CAPITAL EXPENDITURES		\$ <u>101,182</u>	\$ <u>130,637</u>

Note:

D.9 – Other Expenses include Outside Services, Utilities, Business Meals, Travel, Training)

6.	A.	<p><b>Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.</b></p> <p>Proposed charges: \$2,574 per patient day  Contractual adjustments: \$1,802 per patient day  Expected net revenue: \$614 per patient day (also considers bad debt and charity care)</p> <p>There will be no impact to existing patient charges or charge schedules. This is a new service for the hospital.</p>
	B.	<p><b>Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).</b></p> <p>The estimated charges and net revenues were developed utilizing an assumption that 90% of the patients utilizing swing bed services will be Medicare patients, and as such, prevailing Medicare rates are the basis for the charge and net revenue assumptions.</p>
7.	<p><b>Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.</b></p> <p>Swing bed services, if properly utilized as an appropriate case management tool, increase the efficiency of a rural hospital, allowing the hospital to maximize its existing resources to serve a greater population of patients. The projected utilization of 85 patients per year, or an average daily census of 5.3, is sufficient to maintain the cost-effectiveness of the existing hospital staff, as well as to be a profitable service for the hospital.</p>	
8.	<p><b>Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.</b></p> <p>Based on the projected utilization rates and the efficiency of utilizing resources already in place to serve more patients, the project is projected to be profitable within the first year of operation.</p>	
9.	<p><b>Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition,</b></p>	

	<p><b>report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.</b></p> <p>The hospital, and by extension this project, participates in all state and federal funding programs, including Medicare and all TennCare programs.</p>
10.	<p><b>Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.</b></p> <p>See Attachment C.Economic Feasibility-10 and Attachment C.Economic Feasibility-10b.</p>
11.	<p><b>Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:</b></p>
	<p><b>a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.</b></p> <p>This project is as close to being without cost as a Certificate of Need project can be, requiring only minor physical therapy equipment. By far the bulk of the cost is for legal and administrative fees. The alternative to initiating swing beds is to continue to discharge all patients needing skilled nursing services to area nursing homes. There are many patients who want their family member to be able to receive that care in the familiar hospital setting, without having to transfer that family member to a nursing home, particularly for shorter stays that do not require intensive therapy services.</p>
	<p><b>b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.</b></p> <p>Not applicable.</p>

## CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

<b>1.</b>	<p><b>List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.</b></p> <p>Tennova Healthcare Hospitals  Cookeville Regional Medical Center  St. Thomas Hospital  Methodist Medical Center  Vanderbilt Medical Center  Amedisys Home Health Care  Signature Healthcare of Fentress County  Huntsville Manor  Life Care of Wartburg  Oneida Nursing and Rehab Center  Pickett County Care &amp; Rehab  Standing Stone Care &amp; Rehab  Wyndridge Health &amp; Rehab  Cares Hospice  Amedisys Hospice</p> <p><u>Managed Care Contracts:</u>  BCBS (Commercial, TennCare and Medicare)  Beech Street  Bluegrass Family Health  Center Care  Cigna  First Health  GEHA  Humana (Commercial, Tricare and Medicare)  Initial Group  Multiplan  National Provider Network  Perdue Farms  Prime Health  Private Healthcare Systems  United Healthcare (Commercial and TennCare)</p>
<b>2.</b>	<p><b>Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.</b></p>

	<p>The proposal will have a positive effect on the health care system serving this rural market. Providing services in the most convenient way possible for patients is a key tenet of both the State Health Plan as well as the Affordable Care Act. Jamestown RMC is committed to providing care in the most appropriate, convenient and cost-effective way possible, and this project contributes to that goal.</p> <p>While there could be impact to utilization rates of existing providers in the service area of the project, the reality is that it has become more difficult to place patients with other providers, due to staffing and occupancy issues. For the convenience of the patients and the efficiency of the hospital, including the efficiency of its case management function, the swing beds provide a very orderly option for those patients needing care following an acute hospital stay.</p>												
3.	<p><b>Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor &amp; Workforce Development and/or other documented sources.</b></p> <p>Because the swing beds are not new beds, and will be utilized as either medical/surgical or skilled nursing beds, the staffing levels for the nursing unit will not change. The staffing plan for Jamestown RMC's nursing units is to staff with two (2.0) Registered Nurses, supported by 2.0 – 5.0 Licensed Professional Nurses, dependent upon the number of patients in the unit. The RNs and LPNs are also supported by 1.0 – 3.0 Aides and 1.0 Technician. Physical therapy services will be provided by a part-time (0.5 FTE) physical therapist.</p> <p>Jamestown RMC wage scales are in line with prevailing wage patterns in the service area, as published by the Tennessee Department of Labor &amp; Workforce Development.</p> <table> <tr> <td></td> <td><u>JRMC Wage Scale</u></td> <td><u>Prevailing Wage Scale</u></td> </tr> <tr> <td>Registered Nurse</td> <td>\$22.00 - \$35.00</td> <td>\$20.60 - \$28.27</td> </tr> <tr> <td>Licensed Practical Nurse</td> <td>\$16.50 - \$22.00</td> <td>\$12.85 - \$17.50</td> </tr> <tr> <td>Nursing Aide</td> <td>\$8.50 - \$14.00</td> <td>\$8.13 - \$11.19</td> </tr> </table>		<u>JRMC Wage Scale</u>	<u>Prevailing Wage Scale</u>	Registered Nurse	\$22.00 - \$35.00	\$20.60 - \$28.27	Licensed Practical Nurse	\$16.50 - \$22.00	\$12.85 - \$17.50	Nursing Aide	\$8.50 - \$14.00	\$8.13 - \$11.19
	<u>JRMC Wage Scale</u>	<u>Prevailing Wage Scale</u>											
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Licensed Practical Nurse	\$16.50 - \$22.00	\$12.85 - \$17.50											
Nursing Aide	\$8.50 - \$14.00	\$8.13 - \$11.19											
4.	<p><b>Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.</b></p> <p>The applicant does not anticipate having issues filling these positions.</p>												
5.	<p><b>Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff.</b></p>												

	<p><b>These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education.</b></p> <p>The applicant has reviewed, understands, and will comply with all licensing certification requirements.</p>
6.	<p><b>Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).</b></p> <p>Jamestown RMC serves as a training site for the Tennessee Technological Center at Crossville for licensed practical nursing students, and for MedVance for operating room technicians, lab technicians, and pharmacy technicians.</p>
7.	<p>(a) <b>Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.</b></p> <p>Not applicable.</p>
	<p>(b) <b>Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.</b></p> <p><b>Licensure:</b> The Tennessee State Department of Health</p> <p><b>Accreditation:</b> The Joint Commission on Accreditation of Healthcare Facilities.</p>
	<p>(c) <b>If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.</b></p> <p>Jamestown RMC is in good standing with all licensing, certifying, and accrediting agencies. A copy of the current hospital license is attached, as Attachment C. Orderly Development. 7.(c).</p>
	<p>(d) <b>For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.</b></p> <p>The most recent Joint Commission survey report is attached. All deficiencies have been addressed through an approved plan of correction.</p>

	See Attachment C. Orderly Development.7.(d).
8.	<p><b>Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.</b></p> <p>Not applicable.</p>
9.	<p><b>Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project.</b></p> <p>Not applicable.</p>
10.	<p><b>If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.</b></p> <p>The applicant will provide the Tennessee Health Service and Development Agency and/or the reviewing agency information and data as requested.</p>

## PROJECT COMPLETION FORECAST CHART

2012 NOV 9 AM 10 55

January 23, 2013 T.C.A. § 68-11-1609(c): \_\_\_\_\_

Assuming the CON approval becomes the final agency action on that date; indicate the number of days from the above agency decision date to each phase of the completion forecast.

<b>Phase</b>	<b><u>DAYS REQUIRED</u></b>	<b><u>Anticipated Date (MONTH/YEAR)</u></b>
1. Architectural and engineering contract signed		
2. Construction documents approved by the Tennessee Department of Health		
3. Construction contract signed		
4. Building permit secured		
5. Site preparation completed		
6. Building construction commenced		
7. Construction 40% complete		
8. Construction 80% complete		
9. Construction 100% complete (approved for occupancy)		
10. *Issuance of license	45 days	April, 2013
11. *Initiation of service	1 day	April, 2013
12. Final Architectural Certification of Payment		
13. Final Project Report Form (HF0055)		

**\* For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

**Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.**

AFFIDAVIT

2012 NOV 9 AM 10 55

STATE OF Tennessee

COUNTY OF Knox

Melanie B. Robinson, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

Melanie B. Robinson Director  
SIGNATURE/TITLE

Sworn to and subscribed before me this 8<sup>th</sup> day of November, 2012 a Notary  
(Month) (Year)

Public in and for the County/State of Tennessee

Susan E. England  
NOTARY PUBLIC

My commission expires July 7, 2015  
(Month/Day) (Year)



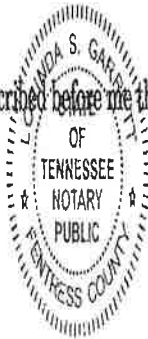
2012 NOV 9 AM 10 55

STATE OF TENNESSEE  
FENTRESS COUNTY

The undersigned - Bill Bowden, Editor and  
Publisher of the Fentress Courier, a newspaper published weekly in Jamestown, Tennessee  
certifies that the attached notice was published for ONE (1)  
Consecutive weeks on the dates of November 7, 2012  
\_\_\_\_\_ and \_\_\_\_\_

Bill Bowden

Sworn to and subscribed before me this 7<sup>th</sup> day of November,  
2012



Linda S. Garrett

Notary Public

My commission expires: March 23, 2015

**NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED**  
This is to provide notice to the Health Services and Development Agency and all interested parties in accordance with T.C.A. § 68-1-1001 et seq., and the Rules of the Health Services and Development Agency that HMA Fentress Hospital, located at 436 Central Avenue, Jamestown, Tennessee 38556, is applying for a Certificate of Need for the establishment of six (6) swing beds and the initiation of swing bed services at the existing medical/surgical beds, which is located at 436 Central Avenue, West, Jamestown, Tennessee 38556. Six (6) existing medical/surgical beds will be converted to swing beds. The number of certified beds with locked inpatient status will be initiated or discontinued and no major medical equipment is requested. No facility renovations are required for this project. The anticipated total cost of the project is \$300,000. The anticipated completion date is November 12, 2012. The contact person for this project is Melanie B. Robinson, Regional Director, Planning and Business Development, who may be reached at: 661-632-5604 ext. 200 or by email at: mrobinso@hmasouthwest.com. Suite 600, Knoxville, Tennessee 37920. 865/632-5604.  
Upon written request by interested parties, a local fact-finding public hearing shall be conducted. Written requests shall be submitted to Health Services and Development Agency, Andrew Jackson Building, 500 Deaderick Street, Suite 850, Nashville, Tennessee 37243.  
Published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1007(c)(1): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is scheduled to be considered. (B) The applicant must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.  
(11-17-11b)

### List of Attachments

Attachment A.4.a	Jamestown Regional Medical Center Organizational Documents
Attachment A.4.b	Corporate Organizational Chart
Attachment B.I.Project Description.1	Equipment List
Attachment B.I.Project Description.2	Corporate Organizational Chart
Attachment B.I.Project Description.3	Service Area Map
Attachment B.I.Project Description.4	Skilled Nursing Bed Demand Calculation
Attachment B.I.Project Description.5	Service Area Provider Listing
Attachment B.I.Project Description.6	Equipment List
Attachment B.I.Project Description.7	Medical Director CV
Attachment B.III.(A)	Plot Plan of Site
Attachment B.IV	Floor Plan of Jamestown RMC Nursing Units
Attachment C.Need.A.1	Skilled Nursing Bed Demand Calculation
Attachment C.Need.B.2	Service Area Provider Current Utilization Chart
Attachment C.Need.Swing Bed Svcs.C	Joint Commission Survey
Attachment C.Need.3	Service Area Map
Attachment C.Economic Feasibility.2.E	CFO Letter
Attachment C.Economic Feasibility-10	Income Statement, September, 2012
Attachment C.Economic Feasibility-10b	Audited Financial Statements
Attachment C.Orderly Development.7.c	Hospital License
Attachment C.Orderly Development.7.d	Most Recent Survey Inspection Report

## **Attachment A.4.a**

State of Tennessee



Department of State

Corporate Filings

312 Eighth Avenue North  
6<sup>th</sup> Floor, William R. Snodgrass Tower  
Nashville, TN 37243

CERTIFICATE OF CONVERSION

(Domestic For-Profit Corporation into LLC  
under TCA 548-21-111)

(For use on or after 7/1/2006)

For Office Use Only

Pursuant to the provisions of §48-21-111 of the Tennessee Business Corporation Act and §48-249-703 of the Tennessee Revised Limited Liability Company Act, the undersigned hereby submits this certificate of conversion:

1. The name and principal business address of the converting domestic corporation is:

HMA Fentress County General Hospital, Inc.

5811 Pelican Bay Blvd., Suite 500

Naples, FL 34108

2. The converting corporation was formed in Tennessee, its date of formation is  
APRIL 29, 2009 (month/day/year), and its SOS control number  
(if known) is: 0601484

3. The converting corporation is being converted to a domestic limited liability company, and the name of the domestic limited liability company as set forth in its article of organization is: HMA Fentress County General Hospital, LLC

4. The plan of conversion is attached to this certificate of conversion and is incorporated herein by reference.

5. The terms and conditions of the conversion have been approved by the unanimous vote of the shareholders; all required approvals of the conversion have been obtained by the converting corporation.

6. The number of members of the limited liability company at the date of conversion is  
one (1)

7. If the conversion is not to be effective upon the filing of the certificate of conversion and articles of organization, then the future effective date and time of the conversion is:

Date: Effective upon filing, Time: \_\_\_\_\_

MAY 1, 2009  
Signature Date

Timothy R. Parry  
Signature

Senior Vice President  
Signer's Capacity (if other than individual capacity)

Timothy R. Parry  
Name (printed or typed)

## PLAN OF CONVERSION

### OF

#### HMA FENTRESS COUNTY GENERAL HOSPITAL, INC.

This Plan of Conversion (the "Plan") is made pursuant to Section 48-21-111 of the Tennessee Business Corporation Act and Section 48-249-703 of the Tennessee Revised Limited Liability Company Act to convert **HMA FENTRESS COUNTY GENERAL HOSPITAL, INC.**, a Tennessee corporation (the "Converting Entity") to a Tennessee limited liability company under the name "**HMA FENTRESS COUNTY GENERAL HOSPITAL, LLC**" (the "Converted Entity"), and shall be effective only upon its due approval and authorization by the unanimous written consent of the holders of all outstanding shares of the capital stock of the Converting Entity.

1. The name of the Converting Entity is HMA Fentress County General Hospital, Inc., a Tennessee corporation, and the name of the Converted Entity is HMA Fentress County General Hospital, LLC, a Tennessee limited liability company.
2. All of the issued and outstanding shares of the Converting Entity are owned by Health Management Associates, Inc. and represent a 100% ownership interest in the Converting Entity. Upon the filing of the Articles of Conversion for the Converting Entity, such 100% ownership of the Converting Entity by Health Management Associates, Inc. shall be converted into a 100% membership interest in the Converted Entity.
3. Subject to the approval and adoption of this Plan by the shareholders and Board of Directors of the Converting Entity, the conversion will become effective upon the filing of the Articles of Conversion with the Tennessee Secretary of State.
4. A true and correct copy of the Articles of Organization of the Converted Entity is attached hereto as Exhibit A.
5. Notification of the approval of the conversion will be deemed to be execution of the Operating Agreement by the members of the Converted Entity.

**EXHIBIT A**

**ARTICLES OF ORGANIZATION  
OF  
HMA FENTRESS COUNTY GENERAL HOSPITAL, LLC**

State of Tennessee



Department of State  
Corporate Filings  
312 Eighth Avenue North  
6<sup>th</sup> Floor, William R. Snodgrass Tower  
Nashville, TN 37243

ARTICLES OF ORGANIZATION  
(LIMITED LIABILITY COMPANY)

(For use on or after 7/1/2006)

For Office Use Only

The Articles of Organization presented herein are adopted in accordance with the provisions of the Tennessee Revised Limited Liability Company Act.

1. The name of the Limited Liability Company is: \_\_\_\_\_  
HMA Fentress County General Hospital, LLC

(NOTE: Pursuant to the provisions of TCA §48-249-106, each limited Liability Company name must contain the words "Limited Liability Company" or the abbreviation "LLC" or "L.L.C.")

2. The name and complete address of the Limited Liability Company's initial registered agent and office located in the state of Tennessee is:

C T Corporation System

(Name)

800 S. Gay Street, Suite 2021

Knoxville

TN 37929

(Street address)

(City)

(State/Zip Code)

Knoxville

(County)

3. The Limited Liability Company will be: (NOTE: PLEASE MARK APPLICABLE BOX)

☐ Member Managed

☒ Manager Managed

☐ Director Managed

4. Number of Members at the date of filing, if more than six (6): one (1)

5. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time is: (Not to exceed 90 days)

Date: Upon Filing, Time: \_\_\_\_\_

6. The complete address of the Limited Liability Company's principal executive office is:

5811 Pelican Bay Blvd., Suite 500, Naples, FL 34108-2710

(Street Address)

(City)

(State/County/Zip Code)

7. Period of Duration if not perpetual: Perpetual

8. Other Provisions:

9. THIS COMPANY IS A NONPROFIT LIMITED LIABILITY COMPANY (Check if applicable) ☐

MAY 1, 2009

Signature Date

Timothy R. Parry

Signature

Senior Vice President of Sole Member

Signer's Capacity (if other than individual capacity)

Timothy R. Parry

Name (printed or typed)

## AMENDED AND RESTATED OPERATING AGREEMENT

This Amended and Restated Operating Agreement (this "**Agreement**") of HMA FENTRESS COUNTY GENERAL HOSPITAL, LLC (the "**Company**") is made effective as of May 5, 2009.

### RECITALS

WHEREAS, the Company was formed as a limited liability company under the Tennessee Limited Liability Company Act (the "**LLC Law**") by the filing of the Certificate of Conversion with attached Articles of Organization by the Tennessee Secretary of State on May 4, 2009 (the "**Company Organization Date**") as part of a series of corporate transactions resulting in the Company being a successor in interest to HMA Fentress County General Hospital, Inc., a California corporation;

WHEREAS, Health Management Associates, Inc., the former sole member of the Company, transferred all of its ownership interest in the Company to Carolinas JV Holdings, L.P., a Delaware limited partnership ("**Carolinas Holdings**"), as of May 5, 2009;

WHEREAS, Carolinas Holdings wishes to amend and restate the original limited liability company agreement of the Company, which shall be superseded and replaced by this Agreement.

NOW, THEREFORE, the undersigned hereby agrees as follows:

**Section 1.     Name of Company.** The name of the limited liability company is HMA Fentress County General Hospital, LLC (the "**Company**").

**Section 2.     Principal Place of Business.** The principal place of business of the Company is 5811 Pelican Bay Blvd., Suite 500, Naples, FL 34108.

**Section 3.     Business of the Limited Liability Company.** The purpose of the Company is to engage in any lawful business purpose. The Company has the authority to do all things necessary or convenient to accomplish this purpose and operate its business.

**Section 4.     Name and Address of the Sole Member.** Carolinas JV Holdings, L.P., a Delaware limited partnership, is the sole member of the Company (the "**Sole Member**"). The Sole Member's address is 5811 Pelican Bay Blvd., Suite 500, Naples, FL 34108.

**Section 5.     Ownership by the Sole Member.** On or prior to the date of this Agreement, the Sole Member made a capital contribution in the amount shown on Schedule A attached hereto in exchange for a 100% ownership interest in the Company.

**Section 6.     Term.** The Company was formed on the Company Organization Date, and shall continue until dissolved in accordance with the terms of this Agreement or by operation of law.

**Section 7.     Management.** The Company shall be managed by Hospital Management Associates, Inc., 5811 Pelican Bay Blvd., Suite 500, Naples, FL 34108 (the "**Manager**"), which shall control the business and affairs of the Company in accordance with the LLC Law and which shall appoint such individuals as the Manager deems appropriate to such offices as the Manager deems necessary in order to carry on the business of the Company. The officers of the Company shall have such authority and duties as shall be delegated to such officers by the Manager.

**Section 8. Officers.** The Manager shall appoint such individuals as the Manager deems appropriate to such offices as the Manager deems necessary in order to carry on the business of the Company. The officers of the Company shall have such authority and duties as shall be delegated to such officers by the Manager.

(a) **Resignation and Removal.** The Manager may resign at any time by giving written notice to the Sole Member. Such resignation shall take effect at the time specified therein or, if no time is specified, then on delivery and, unless otherwise specified therein, the acceptance of such resignation by the Sole Member shall not be needed to make it effective. A Manager may be removed, at any time, with or without cause, by the Sole Member.

(b) **Matters to be Decided by the Members.** No authorization or action taken with respect to the "Major Decisions" subsequently enumerated in this section shall be effective or binding on the Company unless specifically approved by the Sole Member. Major Decisions shall include the following:

- i. the taking of any action which would cause a termination, dissolution or liquidation of the Company, for tax purposes or otherwise;
- ii. any merger or consolidation of the Company with or into another entity;
- iii. the sale of all or substantially all of the assets of the Company;
- iv. consent to a voluntary petition in bankruptcy on behalf of the Company; and
- v. the admission of any additional Members to the Company.

**Section 9. Limitation of Liability; Indemnity.**

(a) Neither the Sole Member nor the Manager will be personally liable for monetary damages for any action taken as a member or manager, or for any failure to take any action, and neither the Sole Member nor the Manager shall be liable for any debts, obligations or liabilities of the Company whether arising in tort, contract or otherwise, solely by reason of being a member or manager.

(b) The Company shall indemnify, defend and hold harmless the Sole Member and the Manager, and any of such party's officers, directors, managers, employees, successors and assigns (each, an "***Indemnified Party***") to the maximum extent permitted by applicable law from and against any and all actual or alleged losses, claims, damages, liabilities, costs or expenses (collectively, "***Damages***") of any nature whatsoever, including attorneys' fees, arising out of or in connection with any action taken or omitted by the Indemnified Party pursuant to authority granted by or otherwise in connection with this Agreement. Any indemnity under this Section shall be paid out of, and to the extent of, Company assets only, including insurance proceeds if available.

(c) All expenses reasonably incurred by an Indemnified Party in connection with a threatened or actual action or proceeding with respect to which such Indemnified Party is or may be entitled to indemnification under this Section shall be advanced or promptly reimbursed by the Company to such Indemnified Party in advance of the final disposition of such action or proceeding upon receipt of an undertaking by such Indemnified Party or on such Indemnified Party's behalf to repay the amount of such

advances, if any, as to which such Indemnified Party is ultimately found not to be entitled to indemnification or, where indemnification is granted, to the extent such advances exceed the indemnification to which such Indemnified Party is entitled.

(d) No repeal or amendment of this Section, insofar as it reduces the extent of the indemnification of any person who could be an Indemnified Party shall, without the written consent of such person, be effective as to such person with respect to any event, act or omission occurring or allegedly occurring prior to (a) the date of such repeal or amendment if on that date such Person is not serving in any capacity for which such Person could be an Indemnified Party or (b) the thirtieth (30th) day following delivery to such Person of written notice of such amendment as to any capacity in which such Person is serving on the date of such repeal or amendment for which such Person could be an Indemnified Party. No amendment of the LLC Law shall, insofar as it reduces the permissible extent of the right of indemnification of an Indemnified Party under this Section, be effective as to such Indemnified Party with respect to any event, act or omission occurring or allegedly occurring prior to the effective date of such amendment. This Section shall be binding on any successor to the Company, including any limited liability company, corporation or other entity which acquires all or substantially all of the Company's assets.

(e) The Company may, but need not, maintain insurance insuring the Company or persons entitled to indemnification under this Section for liabilities against which they are entitled to indemnification under this Section or insuring such persons for liabilities against which they are not entitled to indemnification under this Section.

(f) The indemnification provided by this Section shall not be deemed exclusive of any other rights to which any person covered hereby may be entitled other than pursuant to this Section. The Company is authorized to enter into agreements with any such person or persons providing them rights to indemnification or advancement of expenses in addition to the provisions therefor in this Section to the full extent permitted by law.

(g) The Company, in such instances and to such extent as shall be determined by the Manager, may indemnify and advance expenses to an employee or agent of the Company to the same extent and subject to the same conditions under which the Company may indemnify and advance expenses to the Sole Member and the Manager under this Section; and the Company may indemnify and advance expenses to persons who are not or were not employees or agents of the Company, but who are or were serving at the request of the Company as a manager, director, officer, partner, venturer, proprietor, trustee, employee, agent or similar functionary of another foreign or domestic limited liability company, corporation, partnership, joint venture, sole proprietorship, trust, employee benefit plan or other enterprise against any liability asserted against him and incurred by him in such a capacity or arising out of such person's status as such a person to the same extent that the Company may indemnify and advance expenses to the Sole Member or the Manager under this Section.

**Section 10. Banking.** All funds of the Company shall be deposited in the name of the Company in such checking, money market, cash management or other types of depository or investment accounts maintained by financial institutions including, but not limited to, savings

banks, investment banks, brokerage houses or money managers, as may be designated by the Manager. All withdrawals from such accounts shall be signed by such person(s) as are authorized by the Manager in banking resolutions executed by the Manager with respect to any such account.

**Section 11. Miscellaneous**

(a) **Adoption and Effect of this Agreement.** This Agreement is hereby adopted by the Sole Member pursuant to the LLC Law.

(b) **Captions.** The captions used in this Agreement are inserted for convenience only and are not part of this Agreement.

(c) **Governing Law.** This Agreement and the obligations of the Sole Member hereunder shall be interpreted, construed and enforced in accordance with the laws of the State of Tennessee, without reference to the principles of conflicts of laws.

(d) **Severability.** If any provisions of this Agreement or the application thereof to any person or circumstance shall be invalid or unenforceable to any extent, the remainder of this Agreement and the application of such provisions to other persons or circumstances shall not be affected thereby and shall be enforced to the extent permitted by law.

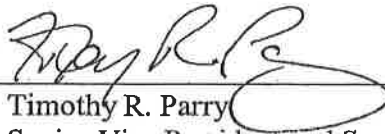
(e) **Default Rules.** Except as expressly provided otherwise in this Agreement, the Company shall be governed by the LLC Law, including all of the statutory default provisions contained therein.

\* \* \* \* \*

IN WITNESS WHEREOF, the Sole Member has signed this Amended and Restated Operating Agreement as of the date first written above for the purpose of adopting it as the operating agreement of HMA Fentress County General Hospital, LLC.

**CAROLINAS JV HOLDINGS, L.P.**

BY: CAROLINAS JV HOLDINGS, GENERAL, LLC  
ITS GENERAL PARTNER

BY:   
Timothy R. Parry  
Senior Vice President and Secretary

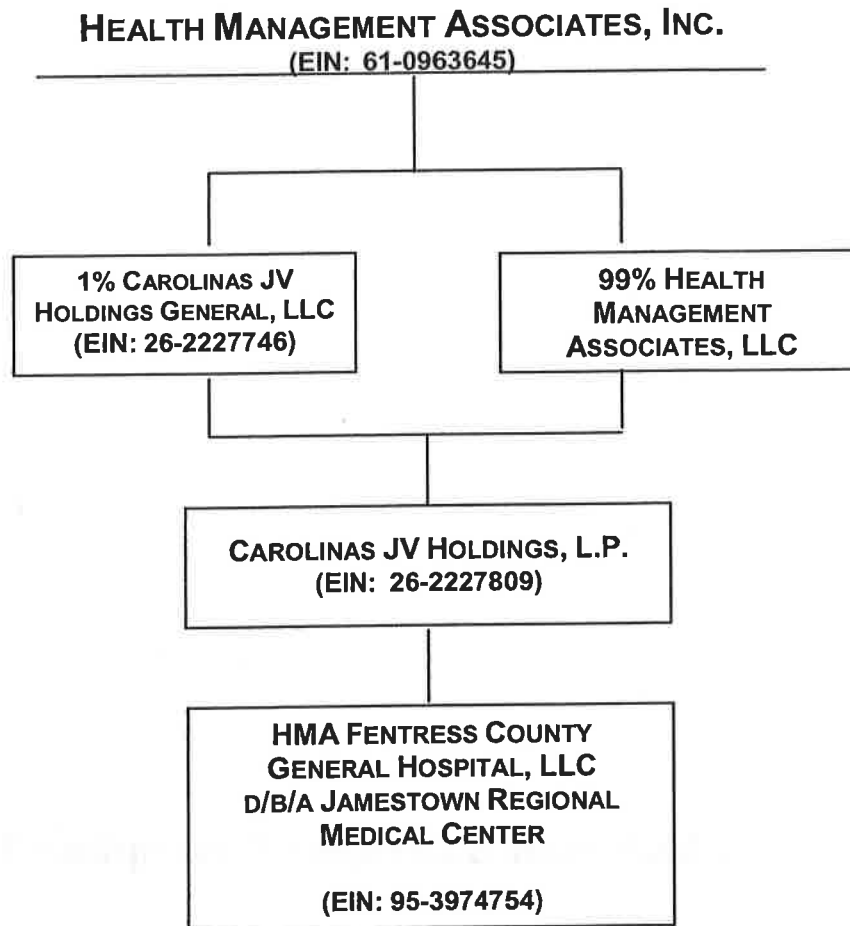
**Schedule A**

Capital Contribution of the Member

\$27,585,000

## **Attachment A.4.b**

**DIRECT AND INDIRECT OWNERSHIP OF  
HMA FENTRESS COUNTY GENERAL HOSPITAL, LLC  
D/B/A JAMESTOWN REGIONAL MEDICAL CENTER**



**Ownership Explanation:**

Carolinas JV Holdings, L.P. is the 100% owner of HMA Fentress County General Hospital, LLC d/b/a Jamestown Regional Medical Center.

Carolinas JV Holdings, L.P. is owned 1% by Carolinas JV Holdings General, LLC and 99% by Health Management Associates, LLC.

Both Carolinas JV Holdings General, LLC and Health Management Associates, LLC are owned 100% by Health Management Associates, Inc.

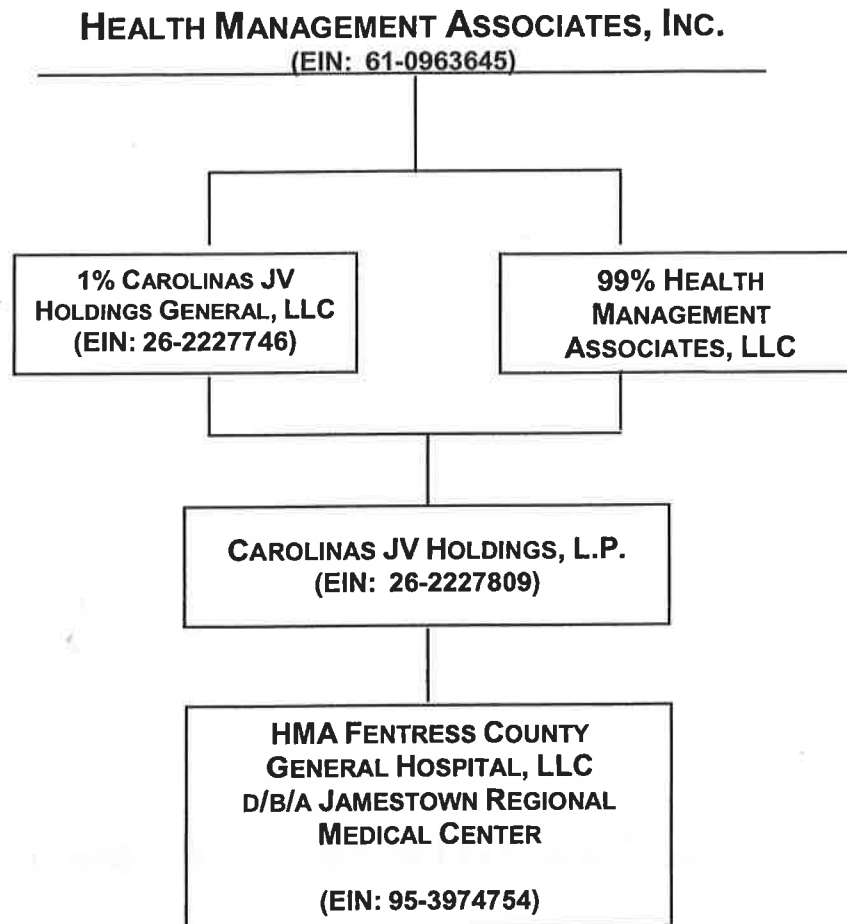
## **Attachment B.I. Project Description.1**

### Equipment Needed - Jamestown RMC Swing Beds

<u>Equipment Description</u>	<u>Catalog Price</u>
1 Trapeze Bar	\$ 250
2 Parallel Bars	\$ 770
3 Pedal Exerciser	\$ 30
4 2 Sided Staircase	\$ 580
5 Table Top Hand Cycle	\$ 820
Subtotal	\$ 2,450
Sales tax (est.)	\$ 227
<b>Total</b>	<b>\$ 2,677</b>

## **Attachment B.I. Project Description.2**

**DIRECT AND INDIRECT OWNERSHIP OF  
HMA FENTRESS COUNTY GENERAL HOSPITAL, LLC  
D/B/A JAMESTOWN REGIONAL MEDICAL CENTER**



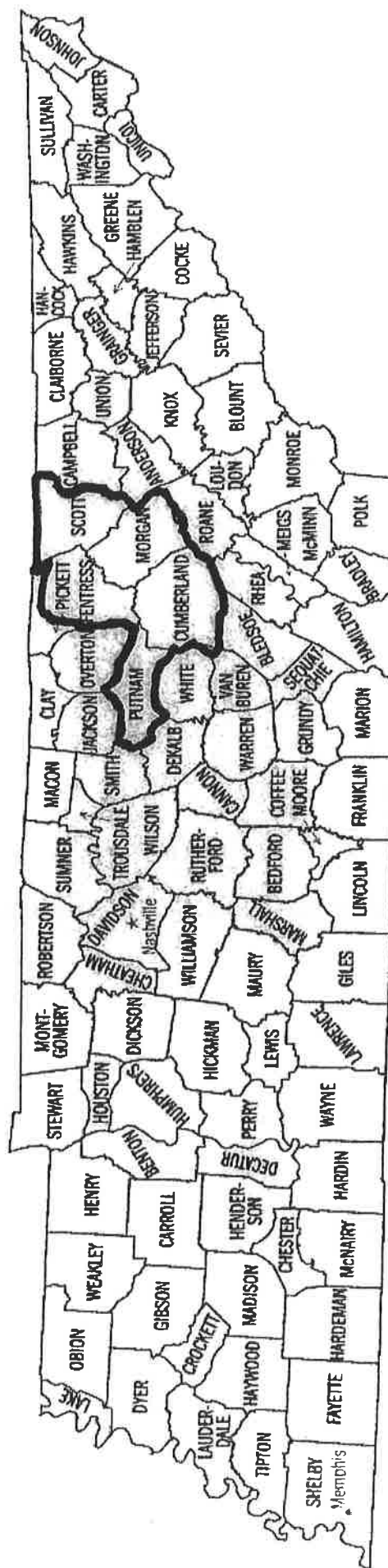
**Ownership Explanation:**

Carolinas JV Holdings, L.P. is the 100% owner of HMA Fentress County General Hospital, LLC d/b/a Jamestown Regional Medical Center.

Carolinas JV Holdings, L.P. is owned 1% by Carolinas JV Holdings General, LLC and 99% by Health Management Associates, LLC.

Both Carolinas JV Holdings General, LLC and Health Management Associates, LLC are owned 100% by Health Management Associates, Inc.

### **Attachment B.I. Project Description.3**



## **Attachment B.I. Project Description.4**

Population Based Demand Calculation - Jamestown Regional Medical Center Swing Bed Services Application

	Population - 2012					Total
	< 65	65-74	75-84	85+		
Fentress	14,998	1,882	904	370	18,154	
Morgan	17,802	1,870	914	310	20,896	
Pickett	3,968	635	351	115	5,069	
Scott	19,986	1,953	922	392	23,253	
Putnam	61,305	6,209	3,445	1,530	72,489	
Cumberland	40,412	8,424	4,357	1,605	54,798	
<b>Total</b>	<b>158,471</b>	<b>20,973</b>	<b>10,893</b>	<b>4,322</b>	<b>194,659</b>	

	Calculated Demand					Total
	< 65	65-74	75-84	85+		
Fentress	7	23	54	56	140	
Morgan	9	22	55	47	133	
Pickett	2	8	21	17	48	
Scott	10	23	55	59	148	
Putnam	31	75	207	230	541	
Cumberland	20	101	261	241	623	
<b>Total</b>	<b>79</b>	<b>252</b>	<b>654</b>	<b>648</b>	<b>1,633</b>	

	Beds in Service*	Unimp. Beds	Total Beds	Demand	Variance
Fentress	140	-	140	140	0
Morgan	69	-	69	133	(64)
Pickett	124	-	124	48	76
Scott	152	-	152	148	4
Putnam	504	-	504	541	(37)
Cumberland	341	-	341	623	(282)
<b>Total</b>	<b>1,330</b>	<b>-</b>	<b>1,330</b>	<b>1,633</b>	<b>(303)</b>

	Population - 2013					Total
	< 65	65-74	75-84	85+		
Fentress	15,003	1,950	932	380	18,265	
Morgan	17,824	1,939	936	315	21,014	
Pickett	3,974	651	364	115	5,104	
Scott	20,077	2,033	955	400	23,465	
Putnam	61,670	6,475	3,495	1,572	73,212	
Cumberland	41,499	8,717	4,440	1,669	56,325	
<b>Total</b>	<b>160,047</b>	<b>21,765</b>	<b>11,122</b>	<b>4,451</b>	<b>197,385</b>	

	Calculated Demand					Total
	< 65	65-74	75-84	85+		
Fentress	8	23	56	57	144	
Morgan	9	23	56	47	136	
Pickett	2	8	22	17	49	
Scott	10	24	57	60	152	
Putnam	31	78	210	236	554	
Cumberland	21	105	266	250	642	
<b>Total</b>	<b>80</b>	<b>261</b>	<b>667</b>	<b>668</b>	<b>1,676</b>	

	Beds in Service	Unimp. Beds	Total Beds	Demand	Variance
Fentress	140	-	140	144	(4)
Morgan	69	-	69	136	(67)
Pickett	124	-	124	49	75
Scott	152	-	152	152	0
Putnam	504	-	504	554	(50)
Cumberland	341	-	341	642	(301)
<b>Total</b>	<b>1,330</b>	<b>-</b>	<b>1,330</b>	<b>1,676</b>	<b>(346)</b>

	Population - 2014					Total
	< 65	65-74	75-84	85+		
Fentress	15,011	2,017	963	389	18,380	
Morgan	17,859	2,004	957	319	21,139	
Pickett	3,982	667	378	117	5,144	
Scott	20,171	2,120	985	407	23,683	
Putnam	62,035	6,747	3,542	1,618	73,942	
Cumberland	41,603	9,018	4,522	1,736	56,879	
<b>Total</b>	<b>160,661</b>	<b>22,573</b>	<b>11,347</b>	<b>4,586</b>	<b>199,167</b>	

	Calculated Demand					Total
	< 65	65-74	75-84	85+		
Fentress	8	24	58	58	148	
Morgan	9	24	57	48	138	
Pickett	2	8	23	18	50	
Scott	10	25	59	61	156	
Putnam	31	81	213	243	567	
Cumberland	21	108	271	260	661	
<b>Total</b>	<b>80</b>	<b>271</b>	<b>681</b>	<b>688</b>	<b>1,720</b>	

	Beds in Service	Unimp. Beds	Total Beds	Demand	Variance
Fentress	140	-	140	148	(8)
Morgan	69	-	69	138	(69)
Pickett	124	-	124	50	74
Scott	152	-	152	156	(4)
Putnam	504	-	504	567	(63)
Cumberland	341	-	341	661	(320)
<b>Total</b>	<b>1,330</b>	<b>-</b>	<b>1,330</b>	<b>1,720</b>	<b>(390)</b>

## **Attachment B.I.Project Description.5**

### Skilled Nursing Beds in the Jamestown Regional Medical Center Service Area

Facility	Licensed Beds	Average Length of Stay - Level II Skilled Beds (in days)	Maximum Patient Days	Actual Patient Days	% Utilization
Signature Healthcare of Fentress County	140	86	51,100	35,385	69.2%
Pickett Care and Rehabilitation Center	69	47	25,185	23,631	93.8%
Life Care Center of Morgan County	124	767	45,260	34,978	77.3%
Huntsville Manor	96	95	35,040	32,661	93.2%
Oneida Nursing & Rehab Center	56	96	20,440	18,690	91.4%
Bethesda Health Care Center	120	23	43,800	40,560	92.6%
Masters Health Care Center	175	21	63,875	60,331	94.5%
NHC Healthcare, Cookeville	94	68	34,310	31,823	92.8%
Standing Stone Care & Rehabilitation Center	115	34	41,975	33,724	80.3%
Life Care Center of Crossville	122	30	44,530	31,127	69.9%
Mary Cravath Wharton Nursing Home	62	n/a	22,630	22,241	98.3%
WyndRidge Health & Rehabilitation Center	157	48	57,305	49,980	87.2%
All Providers	1,330	55	485,450	415,131	85.5%

Source: 2011 Joint Annual Reports

## **Attachment B.I.Project Description.6**

### Equipment Needed - Jamestown RMC Swing Beds

<u>Equipment Description</u>	<u>Catalog Price</u>
1 Trapeze Bar	\$ 250
2 Parallel Bars	\$ 770
3 Pedal Exerciser	\$ 30
4 2 Sided Staircase	\$ 580
5 Table Top Hand Cycle	\$ 820
Subtotal	\$ 2,450
Sales tax (est.)	\$ 227
<b>Total</b>	<b>\$ 2,677</b>

## **Attachment B.I.Project Description.7**

**CURRICULUM VITAE**

**Jonathan David Allred**  
Charity Lane  
Jamestown, Tennessee 38556

**EMPLOYMENT**

Jonathan D. Allred D.Ph., M.D., P.C. – Full-time private practice  
started August 3, 1992 to current date.

**RESIDENCY**

Double-Residency in Internal Medicine and Pediatrics; Charleston Area Medical Center,  
Charleston, W.V. - July, 1988 - June, 1992.

**ACADEMIC DEGREES**

Board Certified - Internal Medicine - August 2003

East Tennessee State University, College of Medicine; Johnson City,  
Tennessee - M.D. - May, 1988.

Samford University, School of Pharmacy; Birmingham, Alabama -  
B.S. - Pharmacy - August, 1984

Tennessee Technological University; Cookeville, Tennessee -  
B.S. - Chemistry - June, 1982.

**LICENSE**

Doctor of Medicine, State of Tennessee - 1991  
Doctor of Pharmacy, State of Tennessee - 1985

**HONORS and AWARDS****Charleston Area Medical Center - Residency**

- \* Excellence in Student Teaching in Pediatrics, 1992
- \* Excellence in Student Teaching in Internal Medicine, 1991.

Page two

## CURRICULUM VITAE

**Jonathan David Allred**

East Tennessee State University Medical School

\* Merck Award

Sanford University

- \* Elected Who's Who Among American Universities and Colleges.
- \* Received for 1983-84 graduate with highest grade point average;
  - Alabama Pharmaceutical Association Award
  - Rho Chi Scholarship Award
  - Phi Delta Chi Scholarship Award
- \* Merck Award for Excellence in Pharmaceutical Chemistry
- \* Dean's Award for outstanding performance in the areas of Pharmacy Administration.
- \* Elected To Rho Chi Scholarship Society
- \* Elected to Lambda Sigma Pharmacy Leadership Society, President 1983 - 1984.

Tennessee Technological University

- \* Elected to Mortor Board for excellence in leadership, scholarship, and service to the University, President 1981-1982.

## PROFESSIONAL SOCIETY MEMBERSHIPS

American Academy of Pediatrics, 1988 to present.  
American College of Physicians, 1988 to present.  
Tennessee Medical Association, 1992 to present.  
American Medical Association, 1984 to present  
American Medical Student Association, 1984 to 1988.  
Phi Rho Sigma Medical Society, 1986 to 1991.  
American Academy of Family Physicians, 1984 to 1988.  
Tennessee Pharmaceutical Association, 1985 to present.  
Student American Pharmaceutical Association, 1982 to 1984.  
Phi Delta Chi Pharmacy Fraternity, Treasurer, 1982 to 1984.

### PERSONAL DATA

Birthdate - September 2, 1960                                  Health - Excellent  
Marital Status - Married                                      Wife's Name - Karen  
Wife's Occupation - Housewife, Certified Public Accountant (inactive)  
Children - DeLayne (17 years), Jacob (14 years)  
Outside Interest - Golf, Travel, Reading

**Attachment B.III.(A)**

SUPPLEMENTAL

June 29, 2009

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132'

Parking Lot

3.94 AC.

OFFICE  
BUILDING

HOSPITAL

Radiology

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595.14'

Parking Lot

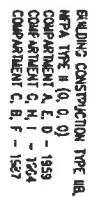
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(Central Avenue West)  
52

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## **Attachment B.IV**



**LIFE SAFETY LEGEND**

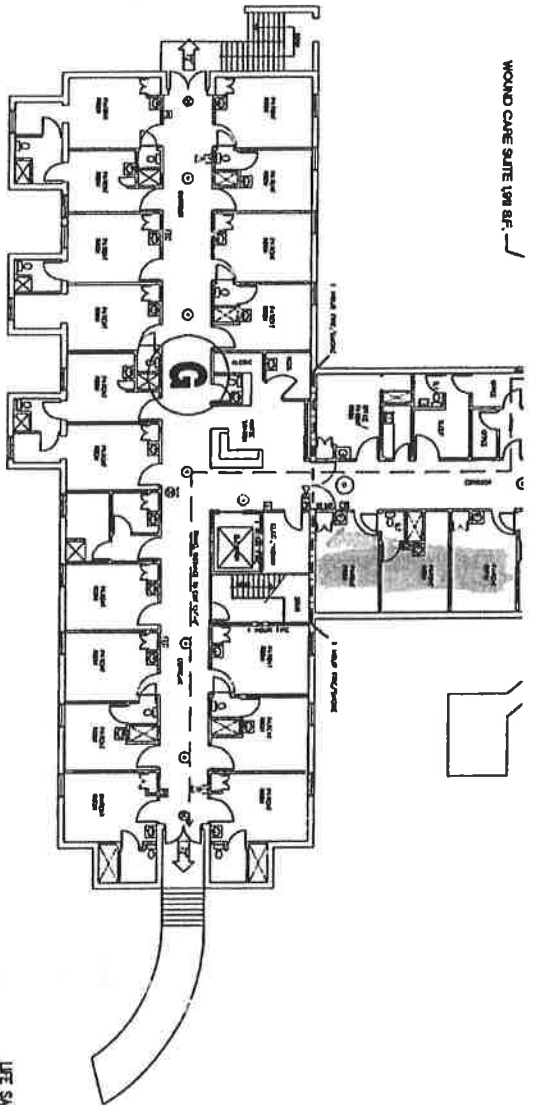
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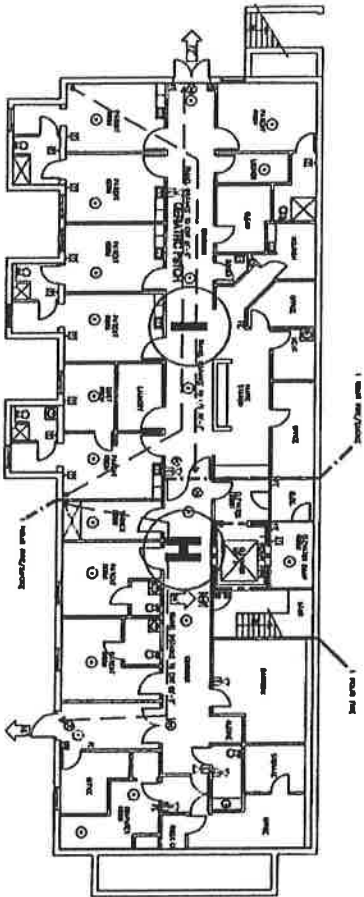
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WOUND CARE SUITE 198 SF.



EXISTING GROUND FLOOR  
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EXISTING LOWER FLOOR  
SCALE 1/8" = 1'-0"

**LIFE SAFETY LEGEND**

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Health Management Associates  
Life Safety Plans  
Jamestown Regional Medical Center

436 Corbett Avenue West, Jamestown, NY 16001  
AN RBCP ARCHITECTS, P.A. PROJECT

**Legend**

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## **Attachment C.Need.A.1**

Population Based Demand Calculation - Jamestown Regional Medical Center Swing Bed Services Application

	Population - 2012				Total
	< 65	65-74	75-84	85+	
Fentress	14,998	1,882	904	370	18,154
Morgan	17,802	1,870	914	310	20,896
Pickett	3,968	635	351	115	5,069
Scott	19,986	1,953	922	392	23,253
Putnam	61,305	6,209	3,445	1,530	72,489
Cumberland	40,412	8,424	4,357	1,605	54,798
<b>Total</b>	<b>158,471</b>	<b>20,973</b>	<b>10,893</b>	<b>4,322</b>	<b>194,659</b>

	Population - 2013				Total
	< 65	65-74	75-84	85+	
Fentress	15,003	1,950	932	380	18,265
Morgan	17,824	1,939	936	315	21,014
Pickett	3,974	651	364	115	5,104
Scott	20,077	2,033	955	400	23,465
Putnam	61,670	6,475	3,495	1,572	73,212
Cumberland	41,499	8,717	4,440	1,669	56,325
<b>Total</b>	<b>160,047</b>	<b>21,765</b>	<b>11,122</b>	<b>4,451</b>	<b>197,385</b>

	Population - 2014				Total
	< 65	65-74	75-84	85+	
Fentress	15,011	2,017	963	389	18,380
Morgan	17,859	2,004	957	319	21,139
Pickett	3,982	667	378	117	5,144
Scott	20,171	2,120	985	407	23,683
Putnam	62,035	6,747	3,542	1,618	73,942
Cumberland	41,603	9,018	4,522	1,736	56,879
<b>Total</b>	<b>160,661</b>	<b>22,573</b>	<b>11,347</b>	<b>4,586</b>	<b>199,167</b>

	Calculated Demand				Total
	< 65	65-74	75-84	85+	
Fentress	7	23	54	56	140
Morgan	9	22	55	47	133
Pickett	2	8	21	17	48
Scott	10	23	55	59	148
Putnam	31	75	207	230	543
Cumberland	20	101	261	241	623
<b>Total</b>	<b>79</b>	<b>252</b>	<b>654</b>	<b>648</b>	<b>1,633</b>

	Calculated Demand				Total
	< 65	65-74	75-84	85+	
Fentress	8	23	56	57	144
Morgan	9	23	56	47	136
Pickett	2	8	22	17	49
Scott	10	24	57	60	152
Putnam	31	78	210	236	554
Cumberland	21	105	266	250	642
<b>Total</b>	<b>80</b>	<b>261</b>	<b>667</b>	<b>668</b>	<b>1,676</b>

	Calculated Demand				Total
	< 65	65-74	75-84	85+	
Fentress	8	24	58	58	148
Morgan	9	24	57	48	138
Pickett	2	8	23	18	50
Scott	10	25	59	61	156
Putnam	31	81	213	243	567
Cumberland	21	108	271	260	661
<b>Total</b>	<b>80</b>	<b>271</b>	<b>681</b>	<b>688</b>	<b>1,720</b>

	Beds in Service*	Unimp. Beds	Total Beds	Demand	Variance
Fentress	140	-	140	140	0
Morgan	69	-	69	133	(64)
Pickett	124	-	124	48	76
Scott	152	-	152	148	4
Putnam	504	-	504	541	(37)
Cumberland	341	-	341	623	(282)
<b>Total</b>	<b>1,330</b>	<b>-</b>	<b>1,330</b>	<b>1,633</b>	<b>(303)</b>

	Beds in Service	Unimp. Beds	Total Beds	Demand	Variance
Fentress	140	-	140	144	(4)
Morgan	69	-	69	136	(67)
Pickett	124	-	124	49	75
Scott	152	-	152	152	0
Putnam	504	-	504	554	(50)
Cumberland	341	-	341	642	(301)
<b>Total</b>	<b>1,330</b>	<b>-</b>	<b>1,330</b>	<b>1,676</b>	<b>(346)</b>

	Beds in Service	Unimp. Beds	Total Beds	Demand	Variance
Fentress	140	-	140	148	(8)
Morgan	69	-	69	138	(69)
Pickett	124	-	124	50	74
Scott	152	-	152	156	(4)
Putnam	504	-	504	567	(63)
Cumberland	341	-	341	661	(320)
<b>Total</b>	<b>1,330</b>	<b>-</b>	<b>1,330</b>	<b>1,720</b>	<b>(390)</b>

## **Attachment C.Need.B.2**

### Skilled Nursing Beds in the Jamestown Regional Medical Center Service Area

Facility	Licensed Beds	Average Length of Stay - Level II Skilled Beds (in days)	Maximum Patient Days	Actual Patient Days	% Utilization
Signature Healthcare of Fentress County	140	86	51,100	35,385	69.2%
Pickett Care and Rehabilitation Center	69	47	25,185	23,631	93.8%
Life Care Center of Morgan County	124	767	45,260	34,978	77.3%
Huntsville Manor	96	95	35,040	32,661	93.2%
Oneida Nursing & Rehab Center	56	96	20,440	18,690	91.4%
Bethesda Health Care Center	120	23	43,800	40,560	92.6%
Masters Health Care Center	175	21	63,875	60,331	94.5%
NHC Healthcare, Cookeville	94	68	34,310	31,823	92.8%
Standing Stone Care & Rehabilitation Center	115	34	41,975	33,724	80.3%
Life Care Center of Crossville	122	30	44,530	31,127	69.9%
Mary Cravath Wharton Nursing Home	62	n/a	22,630	22,241	98.3%
WyndRidge Health & Rehabilitation Center	157	48	57,305	49,980	87.2%
All Providers	1,330	55	485,450	415,131	85.5%

Source: 2011 Joint Annual Reports

**Attachment C.Need.Swing Bed Svcs.C**

# Jamestown Regional Medical Center

Jamestown, TN

has been Accredited by



## The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the  
Hospital Accreditation Program

November 20, 2009

Accreditation is customarily valid for up to 39 months.

*David L. Nahresold*

David L. Nahresold, M.D.  
Chairman of the Board

Organization ID # 7861  
Printed Report Date: 11/20/09

*Mark Chasen*

Mark Chasen, M.D.  
President

The Joint Commission is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at [www.jointcommission.org](http://www.jointcommission.org).





Jamestown Regional Medical Center  
436 Central Avenue West  
Jamestown, TN 38556

**Organization Identification Number: 7841**

**Evidence of Standards Compliance (45 Day) Submitted: 1/4/2010**

**Program(s)**  
Hospital Accreditation

**Executive Summary**

**Hospital Accreditation :** As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.  
You will have follow-up in the area(s) indicated below:

- Measure of Success (MOS) – A follow-up Measure of Success will occur in four (4) months.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

**The Joint Commission  
Summary of Compliance**

<b>Program</b>	<b>Standard</b>	<b>Level of Compliance</b>
HAP	HR.01.06.01	Compliant
HAP	IC.02.02.01	Compliant
HAP	LS.02.01.20	Compliant

## The Joint Commission Summary of CMS Findings

**CoP:** §482.28      **Tag:** A-0618      **Deficiency:** Compliant

**Corresponds to:** HAP

**Text:** §482.28 Condition of Participation: Food and Dietetic Services

The hospital must have organized dietary services that are directed and staffed by adequate qualified personnel. However, a hospital that has a contract with an outside food management company may be found to meet this Condition of Participation if the company has a dietician who serves the hospital on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment.

CoP Standard	Tag	Corresponds to	Deficiency
§482.28(a)(3)	A-0622	HAP - HR.01.06.01/EP5	Compliant

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**CoP:** §482.41      **Tag:** A-0700      **Deficiency:** Compliant

**Corresponds to:** HAP

**Text:** §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.20/EP8, EP13	Compliant

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**CoP:** §482.51      **Tag:** A-0940      **Deficiency:** Compliant

**Corresponds to:** HAP - IC.02.02.01/EP2

**Text:** §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.



Jamestown Regional Medical Center  
436 Central Avenue West  
Jamestown, TN 38556

**Organization Identification Number: 7841**

**Program(s)**  
Hospital Accreditation

**Surveyor(s) and Survey Date(s)**  
John V. Milazzo, MD - (11/16 - 11/19/2009)  
David E. Sladewski, CHSP - (11/16 - 11/16/2009)

**Executive Summary**

**Hospital Accreditation :** As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

- Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Representative.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.



November 20, 2009

Kimberly Anthony  
CEO  
Jamestown Regional Medical Center  
436 Central Avenue West  
Jamestown, TN 38556

Joint Commission ID #: 7841  
Program: Hospital Accreditation  
Accreditation Activity: Unannounced Full  
Event  
Accreditation Activity Completed:  
11/19/2009

Dear Ms. Anthony:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high - quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

With that goal in mind, your organization received Requirement(s) for Improvement during its recent survey. These requirements have been summarized in the Accreditation Report provided by the survey team that visited your organization.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

Sincerely,

Ann Scott Blouin, RN, Ph.D.  
Executive Vice President  
Accreditation and Certification Operations

## The Joint Commission Summary of Findings

**Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day this report is posted to your organization's extranet site:**

<b>Program:</b>	Hospital Accreditation Program	
<b>Standards:</b>	HR.01.06.01	EP5
	IC.02.02.01	EP2
	LS.02.01.20	EP8,EP13

**Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day this report is posted to your organization's extranet site:**

<b>Program:</b>	Hospital Accreditation Program	
<b>Standards:</b>	APR.01.03.01	EP1
	LS.02.01.10	EP3
	RC.01.01.01	EP19

## The Joint Commission Summary of CMS Findings

**CoP:** §482.24      **Tag:** A-0431      **Deficiency:** Standard

**Corresponds to:** HAP

**Text:** §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Standard

**CoP:** §482.28      **Tag:** A-0618      **Deficiency:** Standard

**Corresponds to:** HAP

**Text:** §482.28 Condition of Participation: Food and Dietetic Services

The hospital must have organized dietary services that are directed and staffed by adequate qualified personnel. However, a hospital that has a contract with an outside food management company may be found to meet this Condition of Participation if the company has a dietician who serves the hospital on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment.

CoP Standard	Tag	Corresponds to	Deficiency
§482.28(a)(3)	A-0622	HAP - HR.01.06.01/EP5	Standard

**CoP:** §482.41      **Tag:** A-0700      **Deficiency:** Standard

**Corresponds to:** HAP

**Text:** §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.10/EP3, LS.02.01.20/EP8, EP13	Standard

**CoP:** §482.51      **Tag:** A-0940      **Deficiency:** Standard

**Corresponds to:** HAP - IC.02.02.01/EP2

**Text:** §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

## The Joint Commission Findings

**Chapter:** Accreditation Participation Requirements

**Program:** Hospital Accreditation

**Standard:** APR.01.03.01

ESC 60 days

**Standard Text:** The hospital reports any changes in the information provided in the application for accreditation and any changes made between surveys.

**Primary Priority Focus Area:** Information Management

**Element(s) of Performance:**

1. The hospital notifies The Joint Commission in writing within 30 days of a change in ownership, control, location, capacity, or services offered.

Note: When the hospital changes ownership, control, location, capacity, or services offered, it may be necessary for The Joint Commission to survey the hospital again. If the hospital does not provide written notification to The Joint Commission within 30 days of these changes, the hospital could lose its accreditation.



**Scoring Category :A**

**Score :** Insufficient Compliance

**Observation(s):**

EP 1

Observed in Respiratory Therapy at Jamestown Regional Medical Center site.

Staff identified to the surveyor that the hospital had added a new ambulatory pulmonary rehabilitation service at its main site (initiated November/December 2008) since its last survey without notifying the Joint Commission in writing as is required by the relevant standard.

---

**Chapter:** Human Resources

**Program:** Hospital Accreditation

**Standard:** HR.01.06.01

ESC 45 days

**Standard Text:** Staff are competent to perform their responsibilities.

**Primary Priority Focus Area:** Orientation & Training

**Element(s) of Performance:**

5. Staff competence is initially assessed and documented as part of orientation.



**Scoring Category :C**

**Score :** Partial Compliance

**Observation(s):**

## The Joint Commission Findings

EP.5

§482.28(a)(3) - (A-0622) - (3) There must be administrative and technical personnel competent in their respective duties. This Standard is NOT MET as evidenced by:

Observed in Competency tracer at Jamestown Regional Medical Center site.

During review of an HR file of a RN hired in 2008, there was no documentation of assessment of competence at initial orientation related to the actual observation of application of restraints by the new hire and their release although the Hospital's Education coordinator identified that to be an essential part of the assessment of restraint competency.

Observed in Competency tracer at Jamestown Regional Medical Center site.

During review of the competency file of an OR technician who occasionally works in sterile processing, there was no documentation of a competency in the use of sterile processing in the initial orientation although this responsibility was included in his initial job description. Also, this responsibility was not addressed in his initial ninety day evaluation.

---

**Chapter:** Infection Prevention and Control

**Program:** Hospital Accreditation

**Standard:** IC.02.02.01

ESC 45 days

**Standard Text:** The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

**Primary Priority Focus Area:** Equipment Use

**Element(s) of Performance:**

2. The hospital implements infection prevention and control activities when doing the following: Sterilizing medical equipment, devices, and supplies. (See also EC.02.04.03, EP 4)



**Scoring Category :** A

**Score :** Insufficient Compliance

**Observation(s):**

EP 2

§482.51 - (A-0940) - §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

This Condition is NOT MET as evidenced by:

Observed in the operating room at Jamestown Regional Medical Center site.

During a tracer in the OR, it was identified to the surveyor that instruments are "Flash Sterilized" in open metal trays and transported to the sterile field in the open metal trays which are covered with sterile towels. This is not consistent with AORN recommendations which support "Flash Sterilization" in closed containers or "Flash Packs" which are specifically designed by the manufacturer to use in the Flash autoclaves. These allow penetration of steam to all instrument surfaces, and effectively eliminate contamination of the instruments on transfer from the substerile area to the sterile field. The Hospital identified that they will include Flash Packs in their budgeted items for purchase.

---

**Chapter:** Life Safety

**Program:** Hospital Accreditation

**Standard:** LS.02.01.10

ESC 60 days

## The Joint Commission Findings

**Standard Text:** Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

**Primary Priority Focus Area:** Physical Environment

**Element(s) of Performance:**

3. Walls that are fire-rated for 2 hours (such as common walls between buildings and occupancy separation walls within buildings) extend from the floor slab to the floor or roof slab above and extend from exterior wall to exterior wall. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.2.2)



**Scoring Category :A**

**Score :** Insufficient Compliance

**Observation(s):**

EP 3

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: [http://www.archives.gov/federal\\_register/code\\_of\\_federal\\_regulations/ibr\\_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html).

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in The Building Tour at Jamestown Regional Medical Center site.

The concrete block fire-rated wall in the Electrical room, that is connected to the Laboratory, had a hole in the corner about 6 inches by 12 inches. The hole was stuffed with a large plastic garbage bag and some rags. The wall was inspected through the lab break room, there were openings that were not completely sealed at the top.

---

**Chapter:** Life Safety

**Program:** Hospital Accreditation

**Standard:** LS.02.01.20

ESC 45 days

**Standard Text:** The hospital maintains the integrity of the means of egress.

**Primary Priority Focus Area:** Physical Environment

## The Joint Commission Findings

### Element(s) of Performance:

8. Exits discharge to the outside at grade level or through an approved exit passageway that is continuous and terminates at a public way or at an exterior exit discharge. (For full text and any exceptions, refer to NFPA 101-2000: 7.7)



### Scoring Category : A

Score : Insufficient Compliance

13. Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text and any exceptions, refer to NFPA 101-2000: 7.1.10.1)



### Scoring Category : C

Score : Partial Compliance

### Observation(s):

#### EP 8

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101@2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: [http://www.archives.gov/federal\\_register/code\\_of\\_federal\\_regulations/ibr\\_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html).

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in The Building Tour at Jamestown Regional Medical Center site.

The exit behind Nursing Station one did not terminate at a public way. The exit terminated into a grassy area.

#### EP 13

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101@2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: [http://www.archives.gov/federal\\_register/code\\_of\\_federal\\_regulations/ibr\\_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html).

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in The Building Tour at Jamestown Regional Medical Center site.

Observed and corrected at the time of survey. The egress corridor by the ER lobby had clutter consisting of informational signage and a metal stand containing H1N1 supplies.

Observed in The Building Tour at Jamestown Regional Medical Center site.

Observed and corrected at the time of survey. The egress corridor in the PCU unit had clutter consisting of a metal stand containing H1N1 supplies.

## The Joint Commission Findings

**Chapter:** Record of Care, Treatment, and Services

**Program:** Hospital Accreditation

**Standard:** RC.01.01.01

ESC 60 days

**Standard Text:** The hospital maintains complete and accurate medical records.

**Primary Priority Focus Area:** Information Management

**Element(s) of Performance:**

19.

For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed.



**Scoring Category :C**

**Score :** Insufficient Compliance

**Observation(s):**

EP 19

§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.

This Standard is NOT MET as evidenced by:

Observed in outpatient surgery at Jamestown Regional Medical Center site.

During review of a closed endoscopy record of a patient who underwent colonoscopy and EGD on 11/16/09, it was noted that the surgeon's post procedure progress note was not timed.

Observed in outpatient surgery at Jamestown Regional Medical Center site.

During review of a closed endoscopy record of a second patient who underwent EGD on 11/16/09, it was noted that the surgeon's post procedure progress note was not timed.

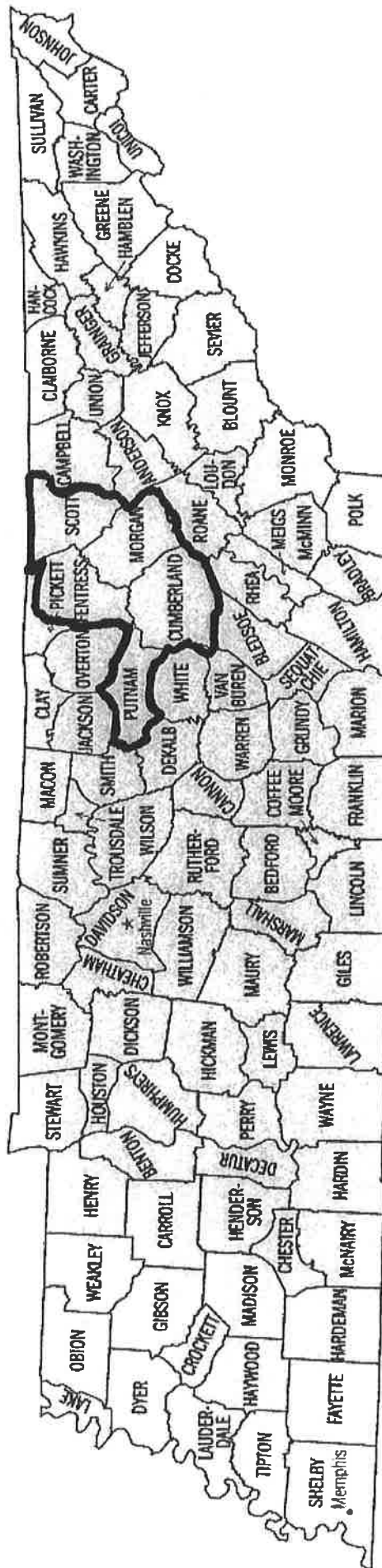
Observed in closed record review at Jamestown Regional Medical Center site.

During review of closed obstetrical records, it was noted that a history and physical was not timed.

Observed in closed record review at Jamestown Regional Medical Center site.

During review of a closed obstetrical record of a normal vaginal delivery, it was noted that the physician's discharge order was not timed.

## **Attachment C.Need.3**



## **Attachment C.Economic Feasibility.2.E**



Health Management<sup>TM</sup>  
Associates

October 10, 2012

Ms. Melanie Hill  
Executive Director  
Health Services and Development Agency  
Andrew Jackson Building  
500 Deaderick Street, Suite 850  
Nashville, Tennessee 37243

Dear Ms. Hill:

This letter is confirmation that as the Chief Financial Officer of Health Management Associates – Tennessee Division, we have sufficient cash reserves to fully fund the capital costs of \$30,677 associated with the initiation of Swing Bed services at Jamestown Regional Medical Center (estimate includes legal and administrative costs, and minor equipment costs). These costs will be funded through Jamestown Regional Medical Center's disbursement account, which is funded daily by Health Management Associates.

We are a part of Health Management Associates, a proprietary health system operating in 15 states.

Sincerely,

Bill Ziesmer  
Chief Financial Officer

## **Attachment C.Economic Feasibility-10**



## **Attachment C.Economic Feasibility-10b**

**2011** ENABLING AMERICA'S  
BEST LOCAL HEALTH CARE.  
ANNUAL REPORT TO SHAREHOLDERS

**We** OF GUIDING PRINCIPLES

Learn how Health Management  
is enabling the best local health  
care in communities throughout  
the United States.



Health Management Associates provides the people, processes, capital and expertise necessary for our hospital and physician partners to fulfill their local missions of delivering superior health care services.

Our strategy of ensuring that the most modern, highest quality care remains close to the citizens of America's rural and non-urban towns gains ever increasing importance as local resources are stretched thin in this difficult economy.

Now, as much as ever, Health Management stands ready to enable the success of our current and prospective partners.

are servant leaders.  
don't settle.  
do the right thing.



The Joint Commission recognized nearly 60 percent of the hospitals Health Management operates as Top Performers on Key Quality Measures—well above national quality performance levels.



On September 30, the seven-hospital system operated by Mercy Health Partners in Knoxville, TN, officially became part of the Health Management family of hospitals and began operating as Tennova Healthcare.



Fortune magazine named Health Management one of the World's Most Admired Companies in Health Care: Medical Facilities. Within that category, Health Management was named the No. 1 company in quality of products/services and in social responsibility.

## TO OUR SHAREHOLDERS AND PARTNERS:

Looking back, if there were one phrase to describe the reason for the company's 2011 record financial results for our shareholders and outstanding quality of care for our patients, it would be "local partnerships."

Thirty-five years ago, Health Management was founded to ensure the availability and vitality of health care in non-urban communities throughout the United States. Today, despite an ever-changing health care and economic landscape, our single mission remains much the same—to enable America's best local health care.

It is our localized focus that drives us to develop very personal partnerships with local Associates, physicians and community leaders. It's through their view of local needs that we shape the vision and strategic plans for each individual health system. Every community needs something unique from its hospital and physicians. In essence, each has its own local mission.

It is our job then to provide the people, processes, capital and expertise that our hospitals and physician partners need to fulfill their local missions of delivering superior health care in their communities. At every level, this is accomplished by being guided by three principles: 1) We are servant leaders; 2) We do the right thing; and 3) We don't settle.

In 2012 and beyond, in whatever form federal regulations take, the need for health care services will continue to grow. Health Management is ready for the growth. We are ready to serve our existing communities. Additionally, we are ready to apply our financial, technological, operational, and patient-centered approach to develop new partnerships with hospitals seeking to continue and expand their local missions of meeting their communities' health care needs.

### STRONG OPERATING RESULTS

By staying true to our guiding principles and maintaining the course set three years ago, 2011 was another outstanding year for the company. Health Management grew its net revenue by 14% to a record \$5.8 billion, increased its income from continuing operations by more than 11% to \$206.3 million, and grew diluted earnings per share by nearly 17% to \$0.70. Operating cash flow from these earnings totaled more than \$544.0 million and was used to acquire or partner with eight new hospitals, representing approximately \$650 million of annual revenue, and to invest in more than \$300 million in capital to expand and upgrade our hospitals' breadth of services.

We remained disciplined in our approach in 2011, staying focused on three fundamental operating initiatives: emergency room operations, physician recruitment, and market service development. This will continue in 2012.

### A STRONG CULTURE

These outstanding 2011 financial results were achieved while—most importantly—reaching our most essential goals: delivering the highest quality care, and developing an outstanding company culture. We were very proud to recently be named as **one of *Fortune* magazine's Most Admired Companies in Health Care**, ranking number one in both Quality of Services and Social Responsibility in the Health Care: Medical Facilities category. These accolades are based on results generated from our patient-centered culture which, in our belief, was the strongest deciding factor in our being chosen in September to acquire seven hospitals in eastern Tennessee from Catholic Health Partners—the largest single acquisition in the company's history.

In order to be an effective, long-term partner with our hospitals and communities, we must not only possess financial strength, but we also must have a sound culture. One focus of 2011 was to build upon the foundation of our cultural initiative, *Getting 2 Great*® (G2G). G2G is a company-wide initiative to build a stronger, more cohesive culture for Health Management's team of Associates, physicians, caregivers and leaders. While each of our hospitals is distinctly different, G2G is designed to ensure we are all working toward our common goals and providing outstanding experiences for patients, families, physicians and Associates.

Six Pillars—**People, Service, Quality, Innovation, Finance and Growth**—provide the foundation for G2G and the care that our hospitals provide each day.

### PEOPLE

It is only through an engaged and happy team of service providers that each hospital's patients have an excellent experience. Our Associates are truly the backbone of our success.

We reward and recognize the contributions of Associates and physicians, create a positive work environment where teamwork is encouraged and provide opportunities for individual growth and achievement.

As Health Management continues to evolve and grow, we must continually reengineer the organizational structure for growth—one that leverages our resources across a wide geographic base and ensures that effective leaders are in



William J. Schoen, Chairman  
Gary D. Newsome, President & Chief Executive Officer

place to enable success. In 2011, we initiated a new organizational structure and bolstered our corporate and divisional leadership ranks with executives capable of leading us through what we believe will be an extended period of strong growth. Associate surveys, which we conduct on a daily basis, are just one measure of our organizational success. In 2011, those surveys indicate that our new structure and leaders are creating a stronger, happier work environment, with more than 83% of our Associates reporting high overall job satisfaction—which in turn leads to high physician and patient satisfaction.

### SERVICE

At Health Management, we are committed to providing outstanding customer service, one patient experience at a time.

In every role, every day, we serve our physicians, fellow Associates, and most importantly, our patients and their families. Service is all encompassing and never-ending. Examples of our commitment include: providing world-class chest pain/stroke centers in partnership with nationally recognized Shands HealthCare/affiliated with the University of Florida; launching hourly patient rounding programs for hospital leadership to ensure frequent interaction with patients and Associates; color-coding uniforms for easier recognition of department personnel by patients; and, redesigning our billing statements so they are easier to read and more customer friendly. Every day, we are looking for ways to better serve—which has resulted in dramatic improvements in our patient satisfaction scores, and in some cases, setting new highs for the company.

## QUALITY

Service at the highest level of excellence is quality. We strive, in everything we do to provide the highest degree of quality health care services to the communities we serve, and to be the recognized leader in outcomes and quality. Indeed, during 2011, thirty-five of our then 59 hospitals, or nearly 60%, were named as **Top Performers on Key Quality Measures by The Joint Commission**, the leading accreditor of health care organizations in America. Likewise, Health Management set the highest Medicare Core Measure Composite Score in company history. Lastly, early this year, two Health Management hospitals, Sparks Health System in Ft. Smith, Arkansas, and Riverview Regional Medical Center in Gadsden, Alabama, were named as **two of the Best Regional Hospitals in the United States by U.S. News & World Report**.

## INNOVATION

Health Management is always striving to elicit and implement ideas for advancing operational, clinical, and service excellence to the benefit of our physicians, Associates and patients.

We continue to invest in technology, having introduced more than 60 state-of-the-art robotic surgical systems to our communities over the last two years, allowing for outpatient orthopedic and other surgeries that were unheard of, and unavailable locally, just five years ago. We are working with our physicians and nurses to develop mobile applications to securely access real-time patient information to better implement care plans. But innovation at Health Management in 2011 reached beyond just technologically advanced equipment. We now successfully deploy data and predictive analytics to enhance revenue cycle management, improve collection efforts, reduce risk through more accurate coding, and effectively manage resources and staffing levels. Predictive analytics offers us unlimited future opportunities to operate more efficiently and improve the hospital experience.

## FINANCE

We are a stronger company today. In 2011, we successfully completed a balance sheet restructuring during the fourth quarter and took advantage of improving capital markets and attractive interest rates to refinance approximately \$3.5 billion of our debt and extend maturities, allowing us to maintain our goal of being an industry leader in financial efficiency, thus enabling capital expenditures in existing markets and enhancing development opportunities in new areas.

## GROWTH

We expect continued growth. Internally, for example, to meet the health care needs of our communities, we have added more than 600 physicians to our medical staffs each year over the past three years, with approximately 670 physicians being added in 2011. That will continue. Externally, we completed two transactions in 2011. First, we partnered with physicians to joint venture the 112-bed Tri-Lakes Medical Center in Batesville, Mississippi. Then, we completed our largest single acquisition of the seven-hospital Mercy Health System in and around Knoxville, Tennessee, which was rebranded Tennova Healthcare. Combined, these hospitals bring approximately \$650 million of additional annual revenue to the company.

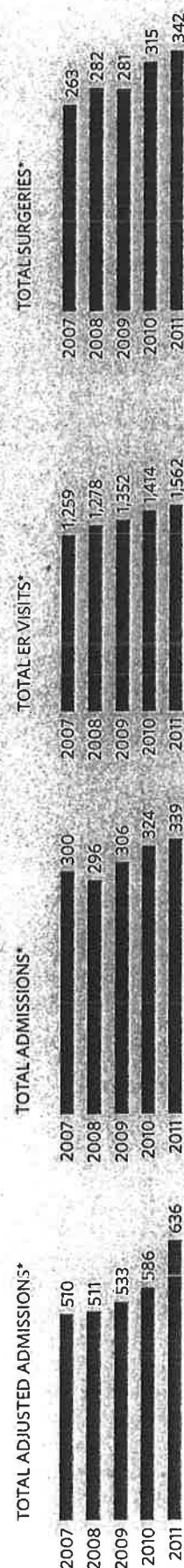
Faced with the challenges of restrictive capital markets, limited IT resources, health care reform, and a languishing economy, many hospitals are seeking partners, such as Health Management, who have access to capital, operational expertise, and a positive culture, to help them survive and continue to achieve their missions of care in non-urban communities. The opportunity to partner with quality hospitals and health systems is as good as we have ever seen it.

These successful partnerships are indicative of our confidence in Health Management's current growth, operational strategies and cultural change. We are discovering that our Associates are finding themselves by losing themselves in the service of others. The prospects of servant leadership, doing the right thing and never settling are attracting Associates of high caliber to our organization and they are making differences in the lives of the people they serve. We are proud to partner with our physicians, nurses, and Associates to continue to innovate health care and deliver the value our patients and stakeholders expect as we enable America's best local health care.



Bill and Gary

Naples, FL  
March 27, 2012



\*All chart data is from continuing operations (in thousands)

**ALABAMA**

Riverview Regional, Gadsden  
Stringfellow Memorial Hospital, Anniston

**ARKANSAS**

Sparks Health System, Fort Smith  
Summit Medical Center, Van Buren

**FLORIDA**

Bartow Regional, Bartow  
Brooksville Regional, Brooksville  
Charlotte Regional, Punta Gorda  
Heart of Florida Regional, Greater Haines City  
Highlands Regional, Sebring  
Lehigh Regional, Lehigh Acres  
Lower Keys Medical Center, Key West  
Pasco Regional, Dade City  
Peace River Regional, Port Charlotte  
Physicians Regional-Coller Blvd, Naples  
Physicians Regional-Pine Ridge, Naples  
Santa Rosa Medical Center, Milton  
Sebastian River Medical Center, Sebastian  
Seven Rivers Regional, Crystal River  
Shands Lake Shore Regional, Lake City  
Shands Live Oak Regional, Live Oak  
Shands Starke Regional, Starke  
Spring Hill Regional, Spring Hill  
St. Cloud Regional, St. Cloud  
Venice Regional, Venice  
Wuesthoff Medical Center-Melbourne, Melbourne  
Wuesthoff Medical Center-Rockledge, Rockledge

**GEORGIA**

Barrow Regional, Winder  
East Georgia Regional, Statesboro  
Walton Regional, Monroe

**KENTUCKY**

Paul B. Hall Regional, Paintsville

**MISSISSIPPI**

Biloxi Regional, Biloxi  
Central Mississippi Medical Center, Jackson  
Crossgates River Oaks Hospital, Brandon  
Gillmore Memorial Regional, Amory  
Madison River Oaks, Canton  
Natchez Community Hospital, Natchez  
Northwest Mississippi Regional, Clarksdale  
River Oaks Hospital, Flowood  
Tri-Lakes Medical Center, Batesville  
Woman's Hospital at River Oaks, Flowood

**MISSOURI**

Poplar Bluff Regional, Poplar Bluff  
Twin Rivers Regional, Kennett

**NORTH CAROLINA**

Davis Regional, Statesville  
Lake Norman Regional, Mooresville  
Sandhills Regional, Hamlet

**OKLAHOMA**

Medical Center of Southeastern Oklahoma, Durant  
Midwest Regional, Midwest City

**PENNSYLVANIA**

Carlisle Regional, Carlisle  
Heart of Lancaster Regional, Lititz  
Lancaster Regional, Lancaster

**SOUTH CAROLINA**

Carolina Pines Regional, Hartsville  
Chester Regional, Chester

**TENNESSEE**

Hartom Regional, Tullahoma  
Jamestown Regional, Jamestown  
Jefferson Memorial Hospital, Jefferson City  
LaFollette Medical Center, LaFollette  
Newport Medical Center, Newport  
North Knoxville Medical Center, Powell  
Physicians Regional, Knoxville  
St. Mary's Medical Center of Scott County, Oneida  
Turkey Creek Medical Center, Knoxville  
University Medical Center, Lebanon

**TEXAS**

Dallas Regional, Mesquite

**WASHINGTON**

Toppenish Community Hospital, Toppenish  
Yakima Regional, Yakima

**WEST VIRGINIA**

Williamson Memorial Hospital, Williamson

**COMPANY PROFILE**

Health Management Associates, Inc. (NYSE: HMA) is an owner and operator of general acute care hospitals in non-urban communities located throughout the United States, primarily in the southeast.

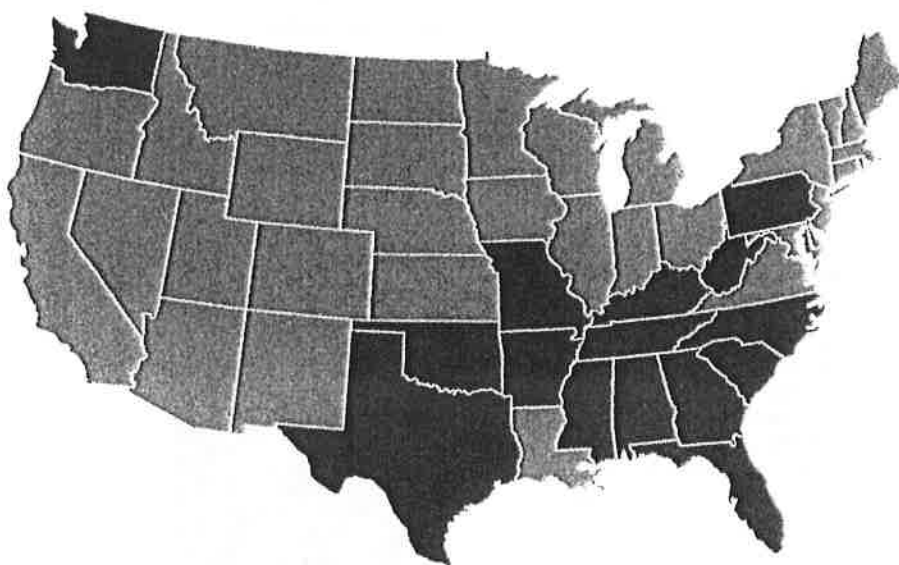
Health Management's mission is to enable America's best local health care. We provide the people, processes, capital and expertise that we believe ensures our local hospitals can achieve their mission to deliver compassionate, high quality health care services that significantly improve the lives of the patients, physicians and communities they serve.

In support of its mission, Health Management:

- Provides dynamic hospital and home office leadership
- Invests capital to renew hospital facilities
- Recruits physicians to expand a hospital's breadth of services in response to community needs
- Introduces proven hospital best practices designed to improve the quality of care, promote wise use of resources, and increase patient and physician satisfaction

At December 31, 2011, Health Management had grown to include 66 hospitals located in 15 states, with a total of approximately 10,300 licensed beds. During 2011, Health Management generated more than \$5.8 billion of net revenue.

Founded in 1977, Health Management's common stock was owned by approximately 900 shareholders of record as of December 31, 2011, including several hundred institutional investors.



#### GROUP OPERATIONAL LEADERSHIP

##### EASTERN GROUP

John M. Starcher, Jr.  
*Group President*

Chris R. Hilton  
*Group Chief Financial Officer*

Angela M. Marchi  
*Atlantic Division President*

Michael W. Garfield  
*Tennessee Division President*

##### FLORIDA GROUP

Alan M. Levine  
*Group President*

David W. Rothenberger  
*Group Chief Financial Officer*

Michael M. Fencel  
*North Florida Division President*

Kathy A. Burke  
*South Florida Division President*

##### SOUTHERN AND WESTERN GROUP

Joe D. Pinion  
*Group President*

Bashar A. Abunaser  
*Group Chief Financial Officer*

William V. Williams, III  
*Southern Division President*

Ann M. Barnhart  
*Western Division President*

#### EXECUTIVE LEADERSHIP

Gary D. Newsome  
*President and Chief Executive Officer*

Kelly E. Curry  
*Executive Vice President and  
Chief Financial Officer*

Robert E. Farnham  
*Senior Vice President - Finance*

Kerry E. Gillespie  
*Executive Vice President - Operations Finance*

Linda A. Epstein  
*Acting General Counsel*

#### HOME OFFICE LEADERSHIP

Kenneth R. Chatfield  
*Chief Information Officer*

Lisa Gore  
*Senior Vice President - Clinical Affairs*

Paul A. Hurst, III  
*Senior Vice President - Government Relations*

James L. Jordan  
*Senior Vice President - MIS*

Kenneth M. Koopman  
*Senior Vice President - Reimbursement*

Peter M. Lawson  
*Executive Vice President - Development*

Gary J. Link  
*Senior Vice President - Administration*

Patrick E. Lombardo  
*Senior Vice President - Human Resources*

Johnny A. Owenby  
*Senior Vice President - Support Services*

Ronald N. Riner, M.D.  
*Chief Medical Officer*

Jack D. Towsley, Jr.  
*Senior Vice President - Payor Relations*

Eric L. Waller  
*Chief Marketing Officer*

#### OUTSTANDING DEPARTMENT DIRECTORS OF THE YEAR

Carlos Felix  
*Bartow Regional Medical Center*

Larry Jervis  
*Paul B. Hall Regional Medical Center*

Ron Kubiak  
*Venice Regional Medical Center*

Michelle Miller  
*Medical Center of Southeastern Oklahoma*

Margaret Stubblefield  
*Crossgates River Oaks Hospital*

#### OUTSTANDING NURSES OF THE YEAR

Lishia Billiter, RN  
*Williamson Memorial Hospital*

Kristine Conroy, RN  
*Charlotte Regional Medical Center*

Randy Parker, RN  
*Gilmore Memorial Regional Medical Center*

Helen Russo, RN  
*Spring Hill Regional Hospital*

LeeAnn Stuart, RN  
*Twin Rivers Regional Medical Center*

#### OUTSTANDING ASSOCIATES OF THE YEAR

Patricia Albin  
*River Oaks Hospital*

Elizabeth Black  
*Sebastian River Medical Center*

Carmen Cappacetti  
*St. Cloud Regional Medical Center*

Robert Conatser  
*Jamestown Regional Medical Center*

Wayne McCloud  
*Chester Regional Medical Center*

#### PRESIDENT'S LEADERSHIP AWARD

The President's Leadership Award was created in 2010 and was awarded posthumously to Bradley E. Jones, our dear Associate who lost his battle to lung disease in February 2010. This annual honor recognizes those individuals with the same qualities we so greatly admired in Brad: selflessness, servant leadership, high-achievement, positivity and a caring spirit.

The distinguished honorees are:

- 2009 Bradley E. Jones
- 2010 John I. Erickson, Jr., Lisa Gore
- 2011 D. Melody Trimble
- 2012 MaryAnn Hodge, Judson Ivy



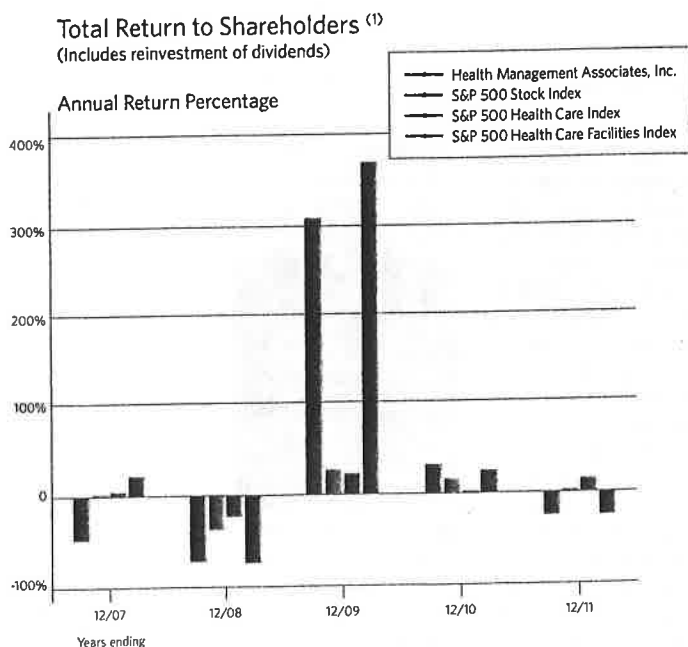
## FINANCIAL HIGHLIGHTS

	YEAR ENDED DEC. 31, 2011	YEAR ENDED DEC. 31, 2010
(Dollars in thousands, except per share amounts)		
<b>OPERATING DATA</b> (From continuing consolidated operations)		
Net revenue	\$ 5,804,451	\$ 5,092,166
Income before income taxes <sup>(a)</sup>	312,405	286,823
Net income attributable to Health Management Associates, Inc. <sup>(b)</sup>	178,710	150,069
Earnings per share from continuing operations attributable to Health Management Associates, Inc. common stockholders (diluted)	\$0.71	\$0.65
Cash flow from continuing operating activities	\$ 544,022	\$ 434,691

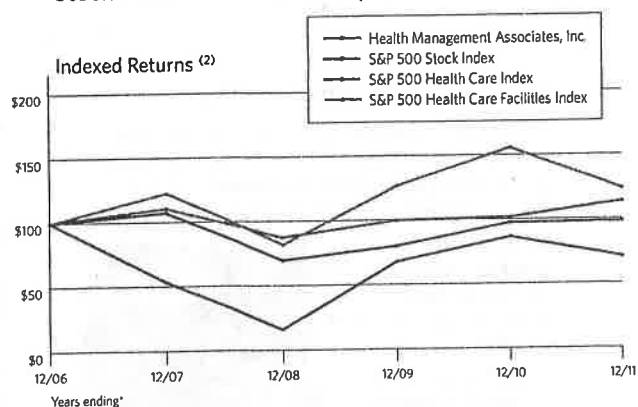
	2011	2010
<b>YEAR-END DATA</b>		
Total assets	\$ 6,004,189	\$ 4,910,085
Long-term debt	3,574,998	3,018,464
Stockholders' equity <sup>(a)</sup>	785,116	533,486
Number of employees	40,600	35,800
Number of hospitals	66	59

(a) Includes amounts attributable to noncontrolling interests.

(b) Includes discontinued operations.



**Stock Price Performance Graph <sup>(1)</sup>**



(1) The graphs on this page compare total return to shareholders (including reinvestment of dividends) and stock price performance, respectively, of Health Management's common stock with the companies in the S&P 500 Stock Index, the S&P 500 Health Care Index and the S&P 500 Health Care Facilities Index during the periods indicated.

(2) Assumes \$100 invested on December 31, 2006.

There can be no assurances that Health Management's stock performance will continue into the future with the same or similar trends depicted in the graphs above. Health Management neither makes nor endorses any predictions as to future stock performance.

## 2011 BOARD OF DIRECTORS

William J. Schoen  
*Chairman of the Board of Directors*  
*Health Management Associates, Inc.*

Gary D. Newsome  
*President and Chief Executive Officer*  
*Health Management Associates, Inc.*

Kent P. Dauten  
*Managing Director*  
*Keystone Capital, Inc.*

Pascal J. Goldschmidt, M.D.  
*Senior Vice President for*  
*Medical Affairs and Dean*  
*University of Miami Leonard M.*  
*Miller School of Medicine*

Donald E. Kiernan  
*Senior Executive Vice President*  
*and Chief Financial Officer*  
*SBC Communications, Inc. (retired)*

Robert A. Knox  
*Senior Managing Director*  
*Cornerstone Equity Investors, LLC*

Vicki A. O'Meara  
*Executive Vice President*  
*Pitney Bowes Inc.*

William C. Steere, Jr.  
*Chairman Emeritus*  
*Pfizer Inc.*

Randolph W. Westerfield, Ph.D.  
*Dean Emeritus and the Charles B.*  
*Thornton Professor of Finance,*  
*Marshall School of Business*  
*University of Southern California*



BOARD OF DIRECTORS (L-R): Pascal J. Goldschmidt, M.D., Robert A. Knox, Randolph W. Westerfield, Ph.D., William J. Schoen, Donald E. Kiernan, Vicki A. O'Meara, William C. Steere, Jr., Gary D. Newsome and Kent P. Dauten

## TECHNOLOGY AND INNOVATION

Technology systems are becoming an increasingly important component of health care delivery. As part of The American Recovery and Reinvestment Act of 2009, the federal government established incentives for health care providers to utilize electronic health records to reduce errors, increase records and data availability, provide clinical decision support, and develop e-prescribing/refill automation. In 2011, Health Management's proprietary information system, the PULSE System<sup>®</sup>, was certified compliant by the federal government and Health Management began receiving additional reimbursement for its systems. Hospitals that partner with us utilize our PULSE System<sup>®</sup> and qualify for additional reimbursement. In 2012, Health Management expects to receive between \$90 and \$120 million dollars of additional reimbursement related to this program.



In today's complex health care landscape, reactive decision making isn't good enough; we must be proactive to best position our company for the future. More data is required and the quality of that data must improve if we are to make effective decisions. Recently, Health Management developed a predictive analytical tool designed to evaluate our millions of patient encounters each year. By utilizing predictive analytics we use a variety of statistical modeling techniques to analyze current and historical facts to forecast future events. These predictive models make use of patterns found in historical and transactional data to identify risks and opportunities and assist us in capital deployment, service line expansion, and revenue cycle management.



UNITED STATES  
SECURITIES AND EXCHANGE COMMISSION  
WASHINGTON, D.C. 20549

FORM 10-K

(Mark One)

☒ Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934

For the fiscal year ended December 31, 2011

or

☐ Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934

For the transition period from \_\_\_\_\_ to \_\_\_\_\_

Commission File Number: 001-11141

HEALTH MANAGEMENT ASSOCIATES, INC.

(Exact name of registrant as specified in its charter)

Delaware  
(State or other jurisdiction of  
incorporation or organization)

61-0963645  
(I.R.S. Employer Identification No.)

5811 Pelican Bay Boulevard, Suite 500  
Naples, Florida  
(Address of principal executive offices)

34108-2710  
(Zip Code)

Registrant's telephone number, including area code: (239) 598-3131

Securities registered pursuant to Section 12(b) of the Act:

Title of each class  
Class A Common Stock, \$0.01 par value

Name of each exchange on which registered  
New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act:

None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☒

Accelerated filer ☐

Non-accelerated filer ☐ (Do not check if a smaller reporting company)

Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ☐ No ☒

As of June 30, 2011, the aggregate market value of the registrant's voting stock held by non-affiliates was approximately \$2.63 billion, as determined by reference to the listed price of the registrant's Class A common stock as of the close of business on such day. For purposes of the foregoing calculation only, all directors and executive officers of the registrant have been deemed affiliates.

As of February 17, 2012, there were 254,435,258 shares of the registrant's Class A common stock, par value \$0.01 per share, outstanding.

Portions of the registrant's definitive proxy statement, to be issued in connection with the Annual Meeting of Stockholders of the registrant to be held on May 22, 2012, have been incorporated by reference into Part III, Items 10, 11, 12, 13 and 14 of this Annual Report.

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## PART I

### Item 1. Business.

#### Overview

Health Management Associates, Inc. by and through its subsidiaries (collectively, “we,” “our” or “us”) operates general acute care hospitals and other health care facilities in non-urban communities. As of December 31, 2011, we operated 66 hospitals with a total of 10,330 licensed beds in Alabama, Arkansas, Florida, Georgia, Kentucky, Mississippi, Missouri, North Carolina, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Washington and West Virginia. See Notes 10 and 15 to the Consolidated Financial Statements in Item 8 of Part II for information about our pending acquisition and divestiture activities.

Services provided by our hospitals include general surgery, internal medicine, obstetrics, emergency room care, radiology, oncology, diagnostic care, coronary care and pediatric services. We also provide outpatient services such as one-day surgery, laboratory, x-ray, respiratory therapy, cardiology and physical therapy. Additionally, some of our hospitals provide specialty services in, among other areas, cardiology (e.g., open-heart surgery, etc.), neuro-surgery, oncology, radiation therapy, computer-assisted tomography (“CT”) scanning, magnetic resonance imaging (“MRI”), lithotripsy and full-service obstetrics. Our facilities benefit from centralized resources, such as purchasing, information technology, finance and accounting systems, legal services, facilities planning, physician recruiting services, administrative personnel management, marketing and public relations.

Our Class A common stock is listed on the New York Stock Exchange under the symbol “HMA.” We were incorporated in Delaware in 1979 but began operations through a subsidiary that was formed in 1977. We became a public company in 1991. We have been named to the list of *Fortune Magazine’s* World’s Most Admired Companies for four of the past six years, appearing as the top hospital company in the “Health Care: Medical Facilities” category for two of those years.

#### Recent Acquisitions and Divestitures

Part of our strategic business plan calls for us to acquire underperforming non-urban general acute care hospitals that are available at a reasonable price, align with our business model and otherwise meet our strict acquisition criteria. We proactively identify acquisition targets and respond to requests for proposals from entities that are seeking to sell or lease hospital facilities. In addition to continually evaluating various hospital and other ancillary health care business acquisition candidates, we are also (i) improving, developing and enhancing the operations of our existing health care facilities and (ii) identifying opportunities to augment our position in the markets where we already have health care operations. We believe that the strength of our balance sheet and cash flow, as well as our available borrowing capacity, provide us the resources needed to pursue acquisition opportunities at this time; however, there can be no assurances that we will close any hospital or other acquisition transactions in 2012 and beyond.

We regularly review and evaluate our portfolio of hospitals and, if an individual hospital no longer meets our short and long-term performance criteria, we consider strategic alternatives, including, in some cases, divestiture. Where appropriate, and consistent with our performance criteria and other strategic objectives, we also explore collaborative relationships with physicians and other health care entities. At any given time, we are actively involved in negotiations concerning possible acquisitions, divestitures and joint ventures. Certain of our recently completed transactions are set forth below.

#### Acquisitions

##### Completed

- On September 30, 2011, one of our subsidiaries acquired from Catholic Health Partners and its subsidiary Mercy Health Partners, Inc. (“Mercy”) substantially all of the assets of Mercy’s seven general acute care hospitals in east Tennessee (collectively licensed to operate 833 beds). Our subsidiary also acquired (i) substantially all of Mercy’s ancillary health care operations that are affiliated with the acquired hospitals (collectively, those ancillary facilities are licensed to operate 74 beds) and (ii) Mercy’s former Riverside hospital campus (which is licensed to operate 293 beds). Our east Tennessee hospital and health care network is now collectively referred to as Tennova Healthcare. The total purchase price for this acquisition was approximately \$532.4 million.
- Effective May 1, 2011, one of our subsidiaries acquired a 95% equity interest in a company that owns and operates Tri-Lakes Medical Center, a 112-bed general acute care hospital in Batesville, Mississippi, and certain related health care operations. The total purchase price for our 95% equity interest was approximately \$38.8 million.

- Effective October 1, 2010, certain of our subsidiaries acquired from Wuesthoff Health Systems, Inc. the following general acute care hospitals and certain related health care operations: (i) 298-bed Wuesthoff Medical Center in Rockledge, Florida; and (ii) 115-bed Wuesthoff Medical Center in Melbourne, Florida. The total purchase price for this acquisition was approximately \$152.0 million.
- Effective July 1, 2010, certain of our subsidiaries acquired from Shands HealthCare a 60% equity interest in each of the following general acute care hospitals and certain related health care operations: (i) 99-bed Shands Lake Shore hospital in Lake City, Florida; (ii) 15-bed Shands Live Oak hospital in Live Oak, Florida; and (iii) 25-bed Shands Starke hospital in Starke, Florida. Shands HealthCare or one of its affiliates continues to hold a 40% equity interest in each of these hospitals. The total purchase price for our 60% interests in these three hospitals was approximately \$21.5 million.

See Note 4 to the Consolidated Financial Statements in Item 8 of Part II for further discussion of our recently completed acquisitions.

#### **Pending**

- On February 3, 2012, one of our subsidiaries signed a definitive agreement with a subsidiary of INTEGRIS Health, Inc. ("INTEGRIS") to acquire an 80% equity interest in each of five Oklahoma-based general acute care hospitals (collectively licensed to operate 226 beds) and certain related health care operations. A subsidiary of INTEGRIS will retain a 20% equity interest in such entities. The total purchase price for our 80% equity interests will be \$60.0 million. This pending acquisition, which we expect to close during the quarter ending June 30, 2012, is discussed at Note 15 to the Consolidated Financial Statements in Item 8 of Part II.

#### ***Divestitures***

- During May 2011, one of our subsidiaries entered into a lease termination agreement for Fishermen's Hospital, a 25-bed hospital in Marathon, Florida, that became effective on July 1, 2011. As part of the agreement, the hospital's remaining equipment, as well as certain working capital items, were sold to our former lessor for approximately \$1.5 million.
- Effective December 31, 2010, certain of our subsidiaries completed the sale of Riley Hospital, a 140-bed general acute care hospital in Meridian, Mississippi, and its related health care operations. The selling price was \$24.0 million, plus a working capital adjustment, and yielded a loss of approximately \$12.4 million.

Our "Discontinued Operations," which include the aforementioned divestitures, are identified at Note 10 to the Consolidated Financial Statements in Item 8 of Part II.

#### **Certain Other Important Developments During 2011**

##### ***Debt Refinancing***

On November 18, 2011, we completed a restructuring of our long-term debt. See Note 2 to the Consolidated Financial Statements in Item 8 of Part II for details of such restructuring and our outstanding long-term debt at December 31, 2011.

##### ***Meaningful Use Incentive Program Certification***

During July 2011, our Pulse System® was deemed compliant and was certified by the Certification Commission for Health Information Technology (CCHIT®), in accordance with the applicable hospital certification criteria adopted by the Secretary of the U.S. Department of Health and Human Services. Our 2011/2012 criteria support the Stage 1 meaningful use measures required to qualify eligible providers and hospitals for funding under the American Recovery and Reinvestment Act of 2009. As a result of our certification and successful compliance with other related criteria, we received approximately \$38.3 million of CCHIT® funds during 2011 from Medicare and Medicaid. Moreover, we expect to receive approximately \$90 million to \$120 million of additional reimbursement during the year ending December 31, 2012.

##### **Market**

Our markets are generally non-urban communities with populations of 30,000 to 400,000 people located primarily in the southeastern United States. Typically, the hospitals we operate are, or we believe can become, the sole or preferred provider of health care services in their respective markets.

Our target markets generally have the following characteristics:

- *A history of being medically underserved.* We believe that we can enhance and increase the level and quality of health care services in many underserved markets.
- *Favorable demographics, including a growing elderly population.* We believe that this growing population uses a higher volume and more acute level of health care services.
- *The existence of patient outmigration trends to urban medical centers.* We believe that, in many instances, we can recruit primary care and specialty physicians based on community needs and purchase new equipment that is necessary to reverse outmigration trends.
- *States in which a certificate of need is required to construct a hospital and add licensed beds to an existing hospital.* We believe that states requiring certificates of need have appropriate barriers to prevent others from building a new hospital, adding licensed beds to an existing hospital or providing additional health care services. We further believe that, in many instances, these factors permit us to be the sole or preferred service provider within a geographic area.

### **Business Strategy**

Our business strategy is to deliver high quality health care services and improve patient and physician satisfaction, improve the operations of our hospitals, utilize efficient management and acquire strategic hospitals and other ancillary health care businesses in non-urban communities.

#### ***Deliver High Quality Health Care Services and Improve Patient and Physician Satisfaction***

All but two of our hospitals (and substantially all of our laboratories and home health agencies) are accredited by The Joint Commission, an independent not-for-profit organization that accredits and certifies more than 15,000 health care organizations and programs based on certain performance standards. We seek to continually improve the quality of the health care services we deliver and the satisfaction of our patients and physicians. To help us in this regard, we use a physician and patient satisfaction survey process to gauge their satisfaction with the level and quality of our services. Surveyed physicians and patients are asked to complete a confidential survey that seeks their perception of, among other things, a hospital's medical treatment, nursing care, attention to physician and patient concerns, communication, admission process, cleanliness and quality of dietary services. The survey results are compared and benchmarked against results from other hospitals across the country. We believe that these surveys provide us with additional data to help improve our hospitals' quality and satisfaction as they compare to our peers and competitors. Each hospital's management team receives the detailed results of the surveys and comparative data regarding their ranking against benchmark statistics. To stress the importance of the survey results, part of our hospital management teams' incentive compensation is based on the levels of quality and satisfaction indicated in those surveys.

As evidence of our commitment to quality, Lake Norman Regional Medical Center, our 123-bed hospital in Mooresville, North Carolina, achieved Magnet Status designation for excellence in nursing services by the American Nurses Credentialing Center's Magnet Recognition Program. The Magnet Recognition Program recognizes health care organizations that demonstrate excellence in nursing practice and adherence to national standards for the organization and delivery of nursing services. Additionally, Venice Regional Medical Center, our 312-bed hospital in Venice, Florida, has been ranked among the nation's Top 100 Acute Care Hospitals and Top 50 Cardiovascular Hospitals according to independent studies by Thomson Reuters. The general acute care hospital study evaluated 3,000 short-term, acute care, non-federal hospitals in nine areas: mortality, medical complications, patient safety, average length of stay, expenses, profitability, cash-to-debt ratio, patient satisfaction and adherence to clinical standards of care. The cardiovascular hospital study examined the performance of 1,022 hospitals by analyzing outcomes for patients with heart failure and heart attacks and those who had coronary bypass surgery and percutaneous coronary interventions such as angioplasties. Venice Regional Medical Center is a five-year recipient of this award. In 2010, Thomson Reuters made the list more exclusive by narrowing it from the top 100 cardiovascular hospitals to the top 50. Seven Rivers Regional Medical Center, our 128-bed hospital in Crystal River, Florida, was identified in 2010 as a recipient of the Patient Safety Excellence Award™ by HealthGrades, Inc. ("HealthGrades"), indicating that its patient safety ratings are in the top 5% of U.S. hospitals. HealthGrades is a leading health care ratings organization, providing ratings and profiles of hospitals, nursing homes and physicians. Seven Rivers Regional Medical Center is one of only 238 hospitals in the country to receive this designation and one of only 15 in Florida. Physicians Regional Health System, our two-hospital system in Naples, Florida, was also recognized by HealthGrades for 2010. Physicians Regional Health System's spine surgery program is among the top 5% in the nation and top ranked in Florida according to HealthGrades. The HealthGrades' study annually assesses patient outcomes - mortality and complication rates - at virtually all of the nearly 5,000 non-federal hospitals in the country.

During 2011, 35 of our hospitals were named as Top Performers on Key Quality Measures according to a report released by The Joint Commission. From a universe of approximately 2,900 Joint Commission-accredited general acute care and critical access hospitals that report core measure performance data, only 405 hospitals nationwide, or approximately 14% of the evaluated hospitals, earned recognition as top performers. In contrast, our 35 hospitals recognized as top performers represented nearly 60% of the 59 hospitals that we operated at the time of the study. To be recognized as a top performer on key quality measures, an organization must meet two 95% performance thresholds. First, it must achieve a composite performance score of 95% or higher after the results of all the accountability measures reported to The Joint Commission are factored into a single score, including measures that had less than 30 eligible cases or patients. Second, it must meet or exceed a 95% performance target score for every single accountability measure for which it reports data, excluding any measures with less than 30 eligible cases or patients.

Listed below are some of the actions that we have undertaken in our ongoing effort to further improve the quality of our health care services.

- *We continue to enhance our medication error prevention program.* An important component of the program is a handheld bedside medication administration system, which is continuing to evolve, designed to help eliminate medication errors by using a clinician-designed bar code scanning device to verify medication orders at the point of care.
- *We continue to implement a program to enhance and upgrade our emergency room clinical systems to more effectively manage patient flow and outcomes.* Thus far, the enhancements have included hardware and software upgrades, as well as the development of uniform clinical guidelines to be implemented company-wide to ensure consistent patient treatment and accurate benchmarking of outcomes. Additionally, our program calls for comprehensive training of all clinical personnel and physicians responsible for emergency room patient care. Our emergency room initiatives are expected to continue for the next couple of years.
- *During 2011, we initiated an electronic document management solution with McKesson Corporation's Horizon Patient Folder™ hospital document management product.* Horizon Patient Folder™ is designed to provide our physicians, health information management personnel and other hospital staff the ability, anytime or anywhere, to review, analyze, code and complete electronic charts within our electronic medical records system. We believe that the adoption of this software will improve patient care, enhance staffing and further ensure regulatory compliance.
- *We sought to improve our computer-based physician access portal system in 2011.* These improvements are designed to allow physicians to access hospital inpatient information using a mobile device such as a smartphone or tablet. To that end, we are working with PatientKeeper, Inc. to design a mobile platform for our physicians so that they can monitor updated patient clinical data from anywhere and at any time. The system, known as PatientKeeper Mobile Clinical Results, will improve care for our patients by allowing physicians to make more timely and accurate decisions regarding a patient's care plan.

#### ***Improve the Operations of our Hospitals***

We seek to increase revenue at our hospitals by providing quality health care, which we believe will ultimately increase admissions, surgical volume, emergency room visits and outpatient business. Our hospitals are administered and directed on a local level by a chief executive officer. A key element of our strategy is establishing and maintaining cooperative relationships with our physicians. We maintain a physician recruitment and development program designed to attract and retain qualified specialists and primary care physicians, in conjunction with our existing physicians and community needs, to broaden the services offered by our hospitals. To this end, we developed a unique program designed to: (i) create attractive practice opportunities for qualified physicians in the communities that are served by our hospitals in order to build outstanding medical staffs; (ii) improve the satisfaction and retention of physicians in our markets; and (iii) create practice models that are sustainable in a competitive health care environment.

Our hospitals seek to increase their patient volume through local marketing programs. Our overall marketing strategy and the individual programs for each of our hospitals are consolidated under central and divisional leadership. One of the benefits of this approach is a streamlined cost-effective process that utilizes a limited number of marketing firms. Using our consolidated marketing programs, we can devise uniform and consistent themes that only require the change of logo and hospital colors to implement company-wide. Additionally, changes to our marketing strategies can be quickly deployed to all of our hospitals and other health care facilities.

We also pursue various clinical means to increase utilization of the services provided by our hospitals, particularly emergency and outpatient services. These include:

- “ER Extra®,” an emergency room operational initiative that is designed to reduce patient wait times, enhance patient satisfaction and improve the quality and scope of patient assessments;
- “Nurse First™,” an emergency room service program that provides for a well-qualified nurse to quickly assess the condition of a patient upon arrival in the emergency room;
- “MedKey™,” a free identification and patient information card that streamlines the registration process; and
- “One Call Scheduling™,” a dedicated phone system that physicians and other medical personnel can use to simultaneously schedule various diagnostic tests and services.

There are numerous opportunities to increase the number of patients who seek treatment at our hospitals and other health care facilities. We believe that improving patient volume rests, in part, on our ability to improve relationships with physicians in the communities where our hospitals operate. In addition to establishing local physician leadership councils where we listen and respond to physician concerns, we routinely evaluate innovative service delivery alternatives that address the ever-changing health care climate. Often times, there already exists a high level of competition for health care services in our markets. We believe that our ultimate success will depend on our ability to improve our quality of care, access to services and patient outcomes, as well as our flexibility, creativity and responsiveness to all involved constituencies.

In our markets, we employ physicians who provide health care services outside of the hospital setting. Our hospitals also assume active roles managing local physician relationships in their markets. As a result of various employed physician initiatives, such as converting physicians to production-based employment arrangements, we have experienced favorable changes in physician referral patterns. We believe that additional opportunities exist to further improve our hospital operations through more efficient management of our employed physicians, which increased in number from approximately 700 at December 31, 2010 to 900 at December 31, 2011.

#### ***Utilize Efficient Management***

We consider our management structure to be decentralized but with centralized support and control. Our hospitals are run by experienced chief executive officers, chief financial officers and chief nursing officers who have both the authority and responsibility for day-to-day hospital operations. Incentive compensation programs have been implemented to reward our managers for achieving and exceeding pre-established goals. We employ a centralized staff at our home office in Naples, Florida to provide support services such as systems design and development, training, human resource management, reimbursement, accounting support, legal services, marketing, purchasing, risk management and construction management. We maintain centralized financial control through fiscal and accounting policies established by our home office for use at all of our subsidiary hospitals. Financial information is consolidated using our proprietary Pulse System® and is monitored daily by our management team. We also participate in a group purchasing organization with other proprietary hospital systems. We believe that this participation allows us to procure medical equipment and supplies at advantageous pricing by leveraging the buying power of the organization's members.

During 2011, our operational reporting structure was comprised of five divisions, each with a divisional senior leader who reported directly to our President and Chief Executive Officer. Each of the five divisions had its own president, chief financial officer and physician recruiting manager with aligned individual hospital and divisional objectives. Effective January 1, 2012, our management structure was changed so as to better address the dynamic growth that we have experienced in recent years. We are now organized into three regional groups (Eastern, Florida, and Southern and Western), each with a group leader who is a senior officer of our company that reports directly to our President and Chief Executive Officer, as well as a chief financial officer who reports to the group leader. In addition, each of the regional groups has two divisions and each division has its own president, chief financial officer and physician recruiting manager with aligned individual hospital and divisional objectives.

During the past several years, we have also recruited and promoted new leadership for centralized support functions such as clinical affairs, marketing, government relations, strategy and analytics, physician recruitment, contracting, human resources, physician relations, nursing and quality.

#### ***Acquire Additional Hospitals and Other Ancillary Health Care Businesses***

We believe that the hospitals we acquire are, or can become, the provider of choice for health care services in their respective communities. When we make an initial evaluation of a potential acquisition, we require that a hospital's market service area have a demonstrated need for the hospital, along with an established physician base

that we believe can benefit from our ability to attract additional qualified physicians to the area based on community needs. In addition to whole hospital acquisitions, we also consider (i) partnering with not-for-profit entities in areas and markets that otherwise meet our acquisition criteria and (ii) investing in or acquiring ancillary health care businesses such as physician practices, ambulatory surgery centers, diagnostic imaging and outpatient urgent care.

We believe that many of the hospitals we acquire are underperforming at the time of acquisition. Upon acquiring a hospital, we conduct a thorough review and, where appropriate, retain existing administrative leadership. We also take other steps, including, among other things, employing a well-qualified chief executive officer, chief financial officer and chief nursing officer, implementing our proprietary management information system (the Pulse System®) and other technological enhancements, recruiting physicians, establishing supplemental quality assessment and efficiency measures, introducing volume purchasing under company-wide agreements, and spending the necessary capital to renovate facilities and upgrade equipment. Our Pulse System® and the other technological enhancements that we implement are designed to provide each hospital's management team with the financial and operational information necessary to operate the hospital efficiently and effectively. We can also assist physicians with case management.

Additionally, we expand and improve the services offered at our acquired hospitals. We strive to provide at least 90% of the acute care needs of each community our hospitals serve and reduce the outmigration of patients to hospitals in larger urban areas. Generally, we have been successful in achieving significant improvement in the operating performance of our newly acquired facilities within 24 to 36 months of acquisition. Moreover, we seek to recover our initial cash investment in an acquired health care facility within four to five years. Once a facility has matured, we seek to achieve incremental growth through the investment of capital, recruitment of physicians based on community needs, expansion and enhancement of health care services, renegotiated agreements with commercial health insurance providers and favorable demographic trends.

#### Selected Operating Statistics

The table below summarizes selected operating statistics, exclusive of our Discontinued Operations, that are typically used by our management, investors and other readers of our consolidated financial statements.

	Years Ended December 31,		
	2011	2010	2009
Licensed beds at the end of the year, excluding inactive facilities (1)	9,868	8,839	8,220
Admissions (2)	338,637	323,917	306,184
Adjusted admissions (3)	635,934	586,060	533,101
Emergency room visits (4)	1,562,028	1,413,831	1,352,044
Surgeries (5)	342,421	314,564	281,285
Patient days (6)	1,424,500	1,350,697	1,281,093
Acute care average length of stay in days (7)	4.2	4.2	4.2
Occupancy rates (8)	42.8%	43.9%	45.3%

- (1) Licensed beds are beds for which a hospital has obtained approval to operate from the applicable state licensing agency.
- (2) Admissions are patients admitted to our hospitals for inpatient treatment. This statistic is a measure of inpatient volume.
- (3) Adjusted admissions are total admissions adjusted for outpatient volume. Adjusted admissions are computed by multiplying admissions (inpatient volume) by the sum of gross inpatient charges and gross outpatient charges and then dividing the resulting amount by gross inpatient charges. This statistic is a measure of total inpatient and outpatient volume.
- (4) The number of emergency room visits is an operational measure that is used to gauge our patient volume. Much of our inpatient volume is a byproduct of a patient's initial encounter with one of our hospitals through an emergency room visit.
- (5) The number of surgeries includes both inpatient and outpatient surgeries. This statistic is indicative of overall patient volume and business trends.
- (6) Patient days is the total number of days that patients are admitted in our hospitals. This statistic is a measure of inpatient volume.
- (7) Acute care average length of stay in days represents the average number of days admitted patients stay in our hospitals. This statistic is a measure of our utilization of resources.
- (8) Occupancy rates are affected by many factors, including the population size and general economic conditions within individual market service areas, the degrees of variation in medical and surgical products, outpatient use of hospital services, quality and treatment availability at competing hospitals and seasonality. This statistic is a measure of inpatient volume.

## Competition

### *Existing hospitals*

In many of the geographic areas where we operate, there are other hospitals and health care entities that provide services comparable to those offered by our hospitals. Generally, competition is limited to a single or small number of hospital competitors in each hospital's market service area. With respect to the delivery of general acute care inpatient services, we believe that most of our hospitals face less competition in their immediate market service area than they would likely face in larger, more urban, communities. However, the health care environment has become more competitive in every market as physicians and ancillary service providers introduce outpatient services. Regardless of the level of competition, we strive to distinguish ourselves based on the quality and scope of the medical services we provide.

Certain of our competitors may have greater resources than we do, may be better equipped than we are and may offer a broader range of services than we do. For example, some hospitals that compete with us are owned by government agencies and are supported by tax revenue, and others are owned by not-for-profit entities and may be supported, to a large extent, by endowments and charitable contributions. Such support is not available to our hospitals. Additionally, outpatient treatment and diagnostic imaging facilities, outpatient surgical centers and freestanding ambulatory surgical centers (including many in which physicians have an ownership interest), specialized care providers (e.g., oncology, physical therapy, etc.), and a growing number of health care clinics located in large retail stores also introduce competitors to the health care marketplace.

A majority of our hospitals are located in states that have certificate of need laws. These laws limit competition by placing restrictions on the construction of new hospital and/or other health care facilities, the addition of new licensed beds or the addition of significant new services. We believe that such states have appropriate barriers to entry and, in many instances, permit us to be the sole or preferred service provider in a particular geographic area.

The competitive position of our hospitals is also increasingly affected by our ability to negotiate service contracts with purchasers of group health care services. Such purchasers include employers, preferred provider organizations ("PPOs") and health maintenance organizations ("HMOs"). PPOs and HMOs attempt to direct and control the use of hospital services by managing care and either receive discounts from a hospital's established charges or pay based on a fixed per diem or a capitated basis, where a hospital receives fixed periodic payments based on the number of members of the organization regardless of the actual services provided. To date, PPOs and HMOs have not adversely affected the competitive position of our hospitals. Employers and traditional health insurers are also increasingly interested in reducing their costs through negotiations with hospitals for managed care programs and discounts from established charges. In return, hospitals secure commitments for a larger number of potential patients. We believe that we have been proactive in establishing or joining such programs to maintain, and even increase, the hospital services we provide. We do not believe that such programs will have a significant adverse impact on our business or operations.

We are in an industry that has a competitive labor market. As such, we face competition attracting and retaining health care professionals. In recent years, there has been a nationwide shortage of qualified nurses and other medical support personnel. To address this shortage, we have improved hospital working conditions and fostered relationships with local nursing schools.

Another important factor contributing to a hospital's competitive advantage is the number and quality of physicians on its staff. Physicians make admitting and other decisions regarding the appropriate course of patient treatment which, in turn, affect hospital revenue. Admitting physicians may also be on the medical staffs of hospitals that we do not operate. By offering quality services and facilities, convenient locations and state-of-the-art medical equipment, we attempt to attract our physicians' patients. Our hospitals try to increase the number, quality and specialties of the physicians in their communities based on local needs. Excluding our 2011 acquisition activity, approximately 650 physicians were recruited or otherwise joined our medical staff during the year ended December 31, 2011. During 2012, we intend to actively recruit a like number of physicians to join our medical staff. When a recruited physician relocates to a community where one of our hospitals is located and agrees to engage in private practice, our subsidiary hospital often advances funds to the physician pursuant to a recruiting agreement to provide financial assistance for the physician to establish a practice. The actual amounts advanced will depend on the financial results of each physician's private practice during a predetermined period, referred to as the measurement period, which generally approximates one to two years. Amounts advanced under these recruiting agreements are considered to be loans and are generally forgiven on a pro rata basis over a period of 12 to 24 months, contingent on the physician continuing to practice in the community served by our hospital.

### ***Acquisitions***

We typically face competition for acquisitions from other for-profit health care companies and not-for-profit multi-hospital groups. Some of those competitors may have greater financial and other resources than we do. Historically, we have been able to complete our acquisitions at prices that we believe are reasonable. However, competitive bidding for acquisition targets could adversely impact our ability to acquire hospitals and other ancillary health care businesses in the future on favorable terms.

### **Sources of Revenue**

#### ***General***

Our revenue from patient charges is dependent on many factors, including surgical volume, inpatient occupancy levels, the level of medical and ancillary services ordered by physicians and provided to patients and the volume of outpatient procedures. We record gross patient service charges on a patient-by-patient basis in the period in which the services are rendered. Patient accounts are billed after the patient is discharged. When a patient's account is billed, our accounting system calculates the reimbursement that we expect to receive based on the services rendered, the type of payor and the contract terms with such payor. We record the difference between gross patient service charges and expected reimbursement as contractual adjustments.

At the end of each month, we estimate our expected reimbursement for unbilled accounts. Estimated reimbursement amounts are calculated on a payor-specific basis and are recorded based on the best information available to us at the time regarding applicable laws, rules, regulations and contract terms. We continually review our contractual adjustment estimation process to consider the effects of changes in applicable laws, rules and regulations, as well as changes to contract terms with managed care health plans that result from negotiations and renewals.

We receive payment for services rendered primarily from:

- the federal government under the Medicare program;
- the states where we operate under each state's Medicaid program;
- commercial insurance and other programs; and
- patients, including co-payments and deductibles.

Co-payments and deductibles are the portion of the patient's bill for medical services that many private and government payors require the patient to pay. Co-payment and deductible amounts vary among payors and are based on the provisions of the health plan in which the patient participates. We estimate that we are currently collecting approximately 50% to 55% of such amounts. In recent years, we have increased our efforts to collect patient co-payments and deductibles at the time services are rendered. Co-payments and deductibles are subject to the same collection practices as other patient accounts receivable.

Our policy is to verify insurance coverage prior to rendering service in order to facilitate timely identification of the payor and the benefits covered. However, under federal law, when the necessity of service and patient condition (e.g., emergency room services, active labor and other similar situations, etc.) are present, those conditions preclude the verification of coverage. We do not track the percent of encounters where coverage is not verified prior to services being rendered.

Virtually all of our billing is processed electronically via our proprietary Pulse System® or a third party billing software program. Charges for services rendered are automatically entered into our billing systems, which edit bills for inconsistencies and improper charges. Inconsistencies are reviewed by billing personnel who resolve such matters before a bill is released. Once a preliminary bill clears the edit process, our systems automatically generate a final bill. Approximately 95% of these bills are sent electronically to third party payors. For the remaining 5% of our bills, paper copies are printed and mailed to third party payors and/or individuals.

Reimbursement rates for routine inpatient services vary significantly depending on the type of service (e.g., acute care, intensive care, etc.) and the geographic location of the hospital where the services are provided. In recent years, outpatient services have steadily increased and presently constitute approximately half of our consolidated net revenue. This increased level of outpatient services is primarily due to advances in medical technology that allow more services to be provided on an outpatient basis, as well as increased pressure from Medicare, Medicaid and commercial insurers to reduce hospital stays and provide services, where possible, on a less expensive outpatient basis. We believe that our outpatient levels are representative of the general trend in the health care industry.

The table below sets forth the approximate percent of hospital net revenue, defined as revenue from all sources after deducting contractual allowances and discounts from established billing rates, that we derive from our primary payor sources.

	Years Ended December 31,		
	2011	2010	2009
Medicare	31%	32%	32%
Medicaid	9	9	9
Commercial insurance and other	50	50	49
Self-pay	10	9	10
	100%	100%	100%

### ***Overview of the Impact of Recent Health Care Reform***

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, which we refer to together as the Health Care Reform Act, were signed into law by President Obama in March 2010 and will dramatically change how health care services are covered, delivered and reimbursed. The Health Care Reform Act is intended to decrease the number of uninsured Americans and reduce health care costs. Among other things, the Health Care Reform Act provides for expanded Medicaid coverage of uninsured individuals, reduced growth in Medicare spending, reductions in Medicare and Medicaid disproportionate share hospital payments and the establishment of programs designed to tie reimbursement to quality (known as value-purchasing programs). The Health Care Reform Act is intended to accomplish its goals and objectives through a combination of public program expansion and private sector health insurance reforms.

Over time, the expansion of private sector and Medicaid coverage under the Health Care Reform Act will likely increase the revenue we receive for services provided to individuals who were previously uninsured. Under the Health Care Reform Act, health insurance coverage is expected to be expanded to cover approximately 32 to 34 million additional people by 2014 through, among other things, the expansion of existing Medicaid programs to cover non-pregnant adults under age 65 with incomes of up to 138% of the federal poverty level (133% of the federal poverty level plus an additional 5% income "disregard" factor). However, reductions in the growth of Medicare payments and decreases in disproportionate share and other hospital reimbursement payments will adversely affect our revenue. To the extent such revenue reductions are not offset by increased revenue from providing care to previously uninsured individuals, the full implementation of the Health Care Reform Act could adversely affect our business and results of operations.

The Health Care Reform Act also contains a number of measures that are intended to further reduce fraud and abuse in the Medicare and Medicaid programs, such as increased funding for fraud and abuse investigations and enforcement, and the required use of recovery audit contractors under the individual state Medicaid programs. Additionally, the law contains significant limitations on hospitals that are partially owned by physicians, including restrictions that generally prohibit increases in the percent of physician ownership and the number of licensed beds, procedure rooms and operating rooms at such joint venture hospitals. At December 31, 2011, we had 24 joint venture hospitals with physician owners.

Many of the Health Care Reform Act's provisions will not take effect until 2014, or later, while others have already become effective or will become effective prior to 2014. The federal government and individual state governments must also interpret and implement the new regulatory requirements, the vast majority of which have yet to be considered. Additionally, the Health Care Reform Act remains subject to significant legislative debate, including possible repeal and/or amendment, and there are substantial legal challenges to various aspects of the Health Care Reform Act that have been made on constitutional grounds. On November 14, 2011, the United States Supreme Court agreed to decide the constitutionality of the Health Care Reform Act (a ruling is expected by July 2012). As a result of these various uncertainties, we are currently unable to predict the overall impact that the full implementation of the Health Care Reform Act will have on us. Other provisions of the Health Care Reform Act that might affect our business and results of operations are discussed below and elsewhere in this Annual Report on Form 10-K, including Item 1A under "Risk Factors."

The Budget Control Act of 2011, or the BCA, was enacted on August 2, 2011. Among other things, the BCA established the Joint Select Committee on Deficit Reduction (the "Deficit Reduction Committee"), a twelve-member bipartisan joint committee of Congress. The primary goal of the Deficit Reduction Committee was to propose legislation to reduce the federal deficit by \$1.5 trillion over the next ten years. Pursuant to the BCA, if the legislation proposed by the Deficit Reduction Committee was not approved by Congress by December 23, 2011 and enacted into law by January 15, 2012, then spending cuts aggregating \$1.2 trillion over the next ten years (less any amount that resulted from earlier Congressional action) would automatically begin in January 2013. The Deficit Reduction Committee failed to propose legislation by December 23, 2011. Therefore, barring action by Congress to the contrary, the reductions and spending cuts dictated by the BCA, which are required to be split equally between defense and non-defense programs, will take effect beginning in January 2013. Although payments to Medicare providers are included in the automatic spending cuts, the BCA provides that Medicare payments may be reduced by no more than 2%. Moreover, the BCA provides that certain other programs, including Medicaid, are exempt from the automatic spending cuts. Although we are unable to determine how the automatic spending cuts required by the BCA will affect Medicare and Medicaid reimbursement in the future, significant reimbursement reductions or other program modifications that result from the BCA could harm our business and results of operations.

## ***Medicare and Medicaid***

### ***Overview***

Medicare is a federal health insurance program, administered by the U.S. Department of Health and Human Services, or HHS, that currently provides health care benefits to individuals age 65 and over, certain disabled persons and certain other individuals with qualifying conditions. Medicaid is a joint federal-state health care benefit program, operating pursuant to a plan developed and administered by each participating state, subject to broadly defined federal requirements, that provides health care benefits to uninsured individuals who are otherwise unable to afford such services. Our hospitals and other health care facilities derive a substantial portion of their net revenue from the Medicare and Medicaid programs. Both such programs are heavily regulated and subject to frequent changes that typically affect reimbursement payments and beneficiary eligibility.

### ***Medicare***

This section should be read in conjunction with the section below entitled "Impact of the Health Care Reform Act on Medicare Reimbursement."

***Inpatient Payments.*** The Medicare program provides payment for inpatient hospital services under a prospective payment system, or PPS. Under the inpatient PPS, hospitals are paid a prospectively determined fixed amount for each hospital discharge. The fixed payment amount per inpatient discharge is established based on each patient's diagnosis related group, or DRG. Each patient admitted for care is assigned to a DRG based on his or her primary admitting diagnosis. Every DRG is assigned a payment rate based on the estimated intensity of hospital resources necessary to treat the average patient with that particular diagnosis. DRG payment rates are based on national average costs from an historic base period and the actual costs incurred by a hospital to provide care are not considered in setting such rates. Although based on national average costs, the DRG standardized amounts and capital payment rates are adjusted by the wage index and geographic adjustment factor for the geographic region in which a particular hospital is located, or reclassified to, and are weighted based on a statistically normal distribution of severity. DRG rates are usually adjusted by an update factor each federal fiscal year, which begins on October 1. The index used as the basis to adjust the DRG rates, known as the "market basket update factor," takes into consideration annual inflation in the purchasing of goods and services experienced by hospitals and other entities. In recent years, the market basket update factor has been lower than the percent increase in costs experienced by hospitals. For federal fiscal years 2011, 2010 and 2009, the market basket update factors were 2.4%, 2.1% and 3.6%, respectively. For federal fiscal year 2012, the market basket update factor is 1.9%, which reflects a 0.1% reduction required by the Health Care Reform Act. Reimbursement rates were increased by another 1.1% for federal fiscal year 2012 to correct a previous misapplication of an urban-rural wage index adjustment that was required by the Balanced Budget Act of 1997 and is referred to as the rural floor budget neutrality adjustment.

The Centers for Medicare & Medicaid Services, or CMS, established Medicare Severity DRGs, or MS-DRGs, which refine the DRG weighting system to more fully capture differences in severity of illness among patients. For example, when MS-DRGs became effective in 2007, 538 DRGs were replaced with 745 MS-DRGs. MS-DRGs are designed to reduce incentives for hospitals to treat only the healthiest and most profitable patients by better taking into account severity of illness in Medicare payment rates. MS-DRGs are also intended to encourage hospitals to improve their coding and documentation of patient diagnoses. To ensure that improvements in coding and documentation do not lead to an increase in aggregate payments without corresponding growth in actual patient severity, CMS uses a negative documentation and coding adjustment. On September 29, 2007, the Transitional Medical Assistance, Abstinence Education, and Qualifying Individuals Programs Extension Act of 2007, or the TMA Act, was signed into law, thereby reducing the documentation and coding adjustment for MS-DRGs for

federal fiscal year 2008 by 0.6%. For federal fiscal year 2009, the negative documentation and coding adjustment for MS-DRGs was 0.9%, yielding a cumulative reduction of 1.5% for federal fiscal year 2009. The TMA Act did not address the adjustment CMS proposed for federal fiscal year 2010. For federal fiscal year 2011, the negative documentation and coding adjustment for MS-DRGs was 2.9%. The TMA Act required CMS to conduct a retrospective review of claims data from federal fiscal years 2008 and 2009 to determine if changes in documentation and coding practices resulted in case mix changes that differ from the adjustments made by the TMA Act. Based on the results of the retrospective data review, CMS is directed to revise payments over federal fiscal years 2011 and 2012 to restore budget neutrality. CMS determined that a negative 5.8% adjustment is necessary to recoup overpayments. The negative 2.9% adjustment for federal fiscal year 2011 was one-half of the recoupment amount, with the second half to be recovered during federal fiscal year 2012. While CMS is completing the recoupment process by applying the remaining 2.9% adjustment, it is simultaneously restoring the negative 2.9% adjustment from federal fiscal year 2011 by adding 2.9% back to the federal fiscal year 2012 reimbursement rates. These adjustments will effectively offset each other and there will be no year-over-year change in the standardized amount due to this recoupment adjustment. CMS is also adopting a prospective adjustment of negative 2.0% in federal fiscal year 2012. This adjustment is designed to ensure that increases in hospital payments due to documentation and coding are not incorporated into the payments made in federal fiscal year 2012 and thereafter.

The net effect of the update factors and adjustments described in the preceding paragraph is a 1.0% increase for federal fiscal year 2012.

*Outpatient Payments.* The majority of hospital outpatient services and certain Medicare Part B services that are furnished to hospital inpatients with no Part A coverage are also paid by Medicare on a PPS basis. However, certain outpatient services, including physical therapy, occupational therapy, speech therapy, durable medical equipment, clinical diagnostic laboratory services and services at freestanding surgical centers and diagnostic facilities, are paid based on fee schedules established by Medicare.

Under the Medicare PPS, services that are clinically related and use similar resources are grouped together into ambulatory payment classifications, or APCs. Depending on the service rendered during an encounter, a patient may be assigned to a single APC or multiple APCs. Medicare pays a set price or rate for each APC, regardless of the actual costs incurred to provide care. Medicare sets the payment rate for each APC based on historical median cost data, subject to geographic modification. The APC payment rates are updated each federal fiscal year based on the market basket. For federal fiscal years 2011, 2010 and 2009, the payment rate update factors were 2.4%, 2.1% and 3.6%, respectively. For federal fiscal year 2012, the payment rate update factor is 1.9%, which reflects a 0.1% reduction required by the Health Care Reform Act.

*Outlier Payments.* In addition to DRG and capital payments, certain of our hospitals qualify for and receive "outlier" payments from Medicare for certain inpatient hospital services. Outlier payments are estimated by CMS to be approximately 5.1% of total inpatient DRG payments. Outlier payments are made for those inpatient discharges where the total cost of care (as determined by using the gross charges adjusted by the hospital's cost-to-charge ratio) exceeds the total DRG payment plus a fixed threshold amount. In determining the cost-to-charge ratio, Medicare uses the latest of either a hospital's most recently submitted or most recently settled cost report. The threshold amounts used in the outlier computation for federal fiscal years 2011, 2010 and 2009 were \$23,075, \$23,140 and \$20,045, respectively. The amount for federal fiscal year 2012 is \$22,385. Excluding our Discontinued Operations, 3.0%, 2.2% and 2.1% of our Medicare inpatient DRG payments were for outlier payments during the years ended December 31, 2011, 2010 and 2009, respectively.

Medicare fiscal intermediaries have been given specific criteria for identifying hospitals that may have received inappropriate outlier payments. The intermediaries are authorized to recover overpayments, including interest, if the actual cost of the DRG stay (which was reflected in the settled cost report) was less than claimed, or if there were indications of abuse. To avoid overpayment or underpayment of outlier cases, hospitals may request changes to their cost-to-charge ratios.

*Disproportionate Share Payments.* An additional reimbursement payment is made to hospitals that serve a significantly disproportionate share of low income Medicare and Medicaid patients. This additional payment is based on a hospital's DRG payments and is paid according to formulae that take into consideration a hospital's percent of low income patients, status, geographic designation and number of licensed beds. As of December 31, 2011, 42 of our hospitals were located in Florida, Mississippi and Tennessee, states that have a significantly disproportionate share of low income Medicare and Medicaid patients.

*Rural Health Clinic Payments.* A rural health clinic is an outpatient facility primarily engaged in furnishing physician and other health services in accordance with federal guidelines. To qualify, a clinic must be located in a medically under-served area that is non-urbanized, as defined by the U.S. Census Bureau. Payments to rural health clinics for covered services are made via an all-inclusive per visit rate. As of December 31, 2011, we operated seven rural health clinics in Missouri and two in each of Florida and Tennessee.

*Ambulatory Surgical Center Payments.* Ambulatory surgical centers are distinct facilities that provide surgical services to patients not requiring hospitalization. Such centers may be licensed by the state in which they operate, depending on individual state requirements. Medicare pays for services provided in ambulatory surgical centers that voluntarily sought and received certification and are approved by CMS. Effective January 1, 2008, CMS instituted a new system for reimbursing ambulatory surgical centers, as was mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or the 2003 Act. The new reimbursement system is based on the outpatient PPS system, taking into account the lower relative costs of procedures performed in an ambulatory surgical center as compared to a hospital outpatient department. As of December 31, 2011, we had a controlling ownership interest in ten ambulatory surgical centers.

*Physician Fees.* The Medicare physician fee schedule for federal fiscal year 2012 contained a 27.4% reduction to the physician fee schedule. However, on February 22, 2012, President Obama signed legislation deferring such reduction to December 31, 2012. Without further legislative action, CMS will be required by Medicare to implement the physician payment reduction on January 1, 2013. As of December 31, 2011, we employed approximately 900 physicians.

*Reimbursement for Bad Debts.* Medicare reimburses hospitals and other health care providers for certain allowable costs that are attributable to uncollectible Medicare beneficiary deductible and coinsurance amounts. Hospitals generally receive an interim pass-through payment for bad debts in an amount determined by the Medicare fiscal intermediary, based on the prior period's bad debt amounts as reported in the hospital's cost report. To be an allowable bad debt, the underlying accounts receivable must be related to a covered service and derived from a deductible and/or coinsurance amount. Additionally, the following conditions must be met: (i) a hospital must be able to establish that reasonable collection efforts were undertaken prior to classification as a bad debt; (ii) the debt was actually uncollectible when classified as worthless; and (iii) sound business judgment established that there was no likelihood of recovery of the debt at any time in the future. In determining reasonable cost subject to reimbursement, the amount of bad debts otherwise treatable as allowable is reduced 30% by Medicare. Amounts received by a hospital as reimbursement for bad debts are subject to audit and recoupment by the fiscal intermediary. Bad debt reimbursement has been a focus of fiscal intermediary audit/recoupment efforts in the past. As part of the payroll tax cut extension that was signed into law on February 22, 2012, allowable bad debt expense will be reduced by 35% for Medicare reimbursement purposes beginning in federal fiscal year 2013.

*General Legislative Changes.* Prior to the passage of the Health Care Reform Act, legislative changes to the Medicare program were historically focused on limiting growth rates for reimbursement and, in some cases, reducing levels of reimbursement for the types of health care services that we provide. For example, the Balanced Budget Act of 1997 included significant reductions in spending levels for the Medicare and Medicaid programs. The Balanced Budget Refinement Act of 1999 mitigated some of the adverse effects of the Balanced Budget Act of 1997 through a "corridor reimbursement approach," whereby a percent of losses under the Medicare outpatient PPS were reimbursed through 2003. The 2003 Act provided an extension, until January 1, 2006, of certain provisions of the Balanced Budget Refinement Act of 1999 for small rural and sole community hospitals. Some of our hospitals qualified for relief under this provision.

The Medicare, Medicaid and State Children's Health Insurance Program Benefits Improvement Act of 2000, or BIPA, made a number of changes to the Medicare and Medicaid programs that affected payments to hospitals. All of our hospitals qualify for some relief under BIPA. Some of the changes made by BIPA that affect our hospitals include: (i) lowering the threshold by which hospitals qualify as rural or small urban disproportionate share hospitals; (ii) decreasing reductions in payments to disproportionate share hospitals that had been mandated by the Balanced Budget Act of 1997 and other Congressional enactments; (iii) capping Medicare beneficiary ambulatory service co-payment amounts; and (iv) increasing the categories and items eligible for increased reimbursement to hospitals for certain outpatient services rendered, such as certain cancer therapy drugs, biologicals and other medical devices.

The 2003 Act made a number of significant changes to the Medicare program. In addition to a prescription drug benefit program that was intended to provide direct relief to Medicare beneficiaries, the 2003 Act also provided a number of benefits to hospitals, including, but not limited to:

- a permanent increase in the base payment rate for rural and small urban hospitals of 1.6%, up to the large urban payment rate;

- the cap on disproportionate share payments for rural and small urban hospitals was set at 12.0% of total inpatient payments; and
- establishment of a physician incentive program for primary care and certain specialty physicians who provide services to individuals in areas having the fewest physicians available to serve, among others, Medicare beneficiaries.

Under the 2003 Act, Medicare payment considerations have been tied to hospital performance and hospital reporting of quality data and measures. Beginning with federal fiscal year 2009, hospitals have been required to report on 30 quality indicators to qualify for their full market basket update. Those hospitals that did not provide the required information have had their market basket update reduced by 2.0%. Our hospitals participated in the quality data reporting, which we believe will form the basis for future payments. We anticipate that more quality data reporting will be required in the future as government payors continue their analysis and possible movement toward a “pay for performance” model and/or value-purchasing programs.

#### *Impact of the Health Care Reform Act on Medicare Reimbursement*

*Inpatient Reimbursement.* The Health Care Reform Act provides for annual decreases to the market basket update factors, including a 0.25% reduction for discharges that occurred on or after April 1, 2010. The Health Care Reform Act also provides for reductions to the market basket update factors for federal fiscal years 2011 through 2019 of 0.25% (2011), 0.1% (2012-13), 0.3% (2014), 0.2% (2015-16) and 0.75% (2017-19). For federal fiscal year 2012 and each subsequent federal fiscal year, the Health Care Reform Act provides for the annual market basket update factors to be further reduced by a productivity adjustment. The amount of that reduction will be based on the projected nationwide productivity gains over the ten years preceding the implementation of the Health Care Reform Act, as measured by the U.S. Bureau of Labor Statistics (which typically uses data that is a few years old). The federal fiscal year 2012 market basket update factor reduction resulting from this productivity adjustment is 1.0%. CMS estimates that the combined market basket update factor and productivity adjustments will increase payments to general acute care hospitals by approximately \$1.13 billion during federal fiscal year 2012, as compared to federal fiscal year 2011, but will also reduce Medicare payments under the inpatient PPS by \$112.6 billion for the federal fiscal years from 2010 to 2019. Decreases in reimbursement rates or increases in such rates below our cost increases would adversely affect our business and results of operations.

The Health Care Reform Act also provides for reduced payments to hospitals based on readmission rates. Beginning in federal fiscal year 2013, inpatient payments will be reduced if a hospital experiences “excessive” readmissions within a period of 30 days from a patient’s discharge due to heart attack, heart failure, pneumonia or other conditions designated by HHS. The reduced payments are applicable to all inpatient discharges, not just discharges relating to the conditions subject to the excessive readmission standard. Moreover, each hospital’s performance will be publicly reported by HHS. HHS has the discretion to determine what constitutes “excessive” readmissions, the amount of the payment reduction and other elements of this program.

Under the Health Care Reform Act, reimbursement will also be reduced based on “hospital acquired condition,” or HAC, rates. An HAC is a condition that a patient develops while admitted as an inpatient in a hospital, such as a surgical site infection. Beginning in federal fiscal year 2015, hospitals that nationally rank in the top 25% of HACs for all hospitals in the previous year will receive a 1% reduction in their total Medicare payments. Moreover, effective July 1, 2011, the Health Care Reform Act prohibited the use of federal funds under the Medicaid program to reimburse providers for medical services provided to treat HACs.

*Outpatient Reimbursement.* The Health Care Reform Act provides for reductions to the market basket update factor for outpatient hospital payments for calendar years 2011 through 2019 of 0.25% (2011), 0.1% (2012-13), 0.3% (2014), 0.2% (2015-16) and 0.75% (2017-19). For calendar year 2012 and each subsequent calendar year, the Health Care Reform Act provides for the annual market basket update factor to be further reduced by a productivity adjustment. The amount of that reduction will be based on the projected nationwide productivity gains over the preceding ten years.

*Disproportionate Share Payments.* Under the Health Care Reform Act, beginning in federal fiscal year 2014, Medicare disproportionate share payments will be reduced to 25% of the amount they otherwise would have been absent the new law. The remaining 75% of the amount that would otherwise be paid as Medicare disproportionate share payments will be pooled, and this pool will be further reduced each year by a formula that reflects reductions in the level of uninsured individuals who are under 65 years of age. Under this provision, the greater the level of coverage for the uninsured, the more the Medicare disproportionate share payment pool will be reduced. Each eligible hospital will ultimately be paid an allocated amount from the pool based on its level of uncompensated care.

*Ambulatory Surgical Center Payments.* Beginning in federal fiscal year 2011, the Health Care Reform Act reduced reimbursement for ambulatory surgical centers through a productivity adjustment to the market basket update factor similar to the productivity adjustment for inpatient and outpatient hospital services.

*Value-Based Purchasing.* The Health Care Reform Act establishes a value-based purchasing program to further link reimbursement payments to quality and efficiency. Beginning with federal fiscal year 2013, HHS will implement a value-based purchasing program that will reduce inpatient PPS payment amounts for all discharges by federal fiscal year as follows: 1.0% for 2013; 1.25% for 2014; 1.5% for 2015; 1.75% for 2016; and 2.0% for 2017 and subsequent years. For each federal fiscal year, the total amount collected from these reductions will be pooled and used to fund payments to hospitals that meet certain quality performance standards. HHS will have the authority to determine the quality performance measures, the quality performance standards hospitals must achieve to meet the quality performance measures and the methodology for calculating payments to hospitals that meet the required quality threshold. HHS will also determine the amount each eligible hospital will receive from the pool created by the reductions under the value-based purchasing program.

*Bundled Payment Pilot Programs.* The Health Care Reform Act requires HHS to establish a five-year, voluntary national bundled payment program for Medicare services beginning no later than January 1, 2013. Under the program, providers would agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care. HHS will have discretion to determine how the program will function, including a determination of the medical conditions that will be covered by the program and the reimbursement amount for each condition.

*Electronic Health Records.* The Health Care Reform Act provided for Medicare and Medicaid incentive payments beginning in federal fiscal year 2011 for eligible hospitals and calendar year 2011 for eligible professionals that have adopted and meaningfully use certified electronic health record, or EHR, technology. A total of at least \$20 billion in incentives is being made available through the Medicare and Medicaid EHR incentive programs to eligible hospitals and eligible professionals. Through November 2011, CMS reports that it had paid nearly \$2 billion in combined meaningful use incentive payments for Medicare and Medicaid.

Under the Medicare incentive program, general acute care hospitals that demonstrate meaningful use of EHR technology in each year of participation will receive incentive payments for up to four fiscal years. To maximize their incentive payments, hospitals must participate in the incentive program by federal fiscal year 2013. Beginning in federal fiscal year 2015, hospitals that fail to demonstrate meaningful use of certified EHR technology will receive reduced market basket updates under inpatient PPS.

Eligible professionals who demonstrate meaningful use of EHR technology in each year of participation are entitled to incentive payments for up to five payment years in an amount equal to 75% of their estimated Medicare allowed charges for covered professional services furnished during the relevant calendar year, subject to an annual limit. Eligible professionals must participate in the incentive payment program by calendar year 2012 to maximize their incentive payments and must participate by calendar year 2014 to receive any incentive payments. Beginning in calendar year 2015, eligible professionals who do not demonstrate meaningful use of certified EHR technology will face Medicare payment reductions.

States may voluntarily implement a Medicaid EHR incentive program. For participating states, the Medicaid EHR incentive program will provide incentive payments to (i) general acute care hospitals and eligible professionals that meet certain volume percentages of Medicaid patients and (ii) children's hospitals. Eligible professionals can only participate in either the Medicaid EHR incentive program or the Medicare EHR incentive program and can change this election only one time. Hospitals may participate in both the Medicare and Medicaid EHR incentive programs.

To qualify for incentive payments under the Medicaid program, providers must adopt, implement, upgrade or demonstrate meaningful use of, certified EHR technology during their first participation year or successfully demonstrate meaningful use of certified EHR technology in subsequent participation years. Payments may be received for up to six participation years. There is no penalty for hospitals or professionals under Medicaid for failing to meet EHR meaningful use requirements.

#### *Medicaid*

This section should be read in conjunction with the section below entitled "Impact of the Health Care Reform Act on Medicaid Reimbursement."

Each state is responsible for administering its own Medicaid program, payment rates and methodologies, as well as covered services, all of which vary from state to state. Although the actual rates vary by state, between 50% and 73% of Medicaid funding comes from the federal government, with the balance shared by state and local

governments. The most common payment methodologies include prospective payment systems and programs that negotiate payment rates with individual hospitals. Generally, Medicaid payments are less than Medicare payments and are often less than a hospital's patient care costs. Hospitals that have an unusually large number of low-income patients (i.e., those with a Medicaid utilization rate of at least one standard deviation above the mean Medicaid utilization, or have a low income patient utilization rate exceeding 25%) are eligible to receive a disproportionate share adjustment. However, Congress has established a national limit on disproportionate share hospital adjustments.

In light of continued economic uncertainty, projected increases to Medicaid program costs and burgeoning budget deficits, the federal government and many states are currently considering ways to limit increases and/or cut Medicaid funding, which could adversely affect future Medicaid payments that we receive. The American Recovery and Reinvestment Act of 2009, or the Economic Stimulus Bill, was signed into law in 2009 and, among other things, allocated supplemental federal funding to each state that could be used to benefit individual state Medicaid programs. Although some states used portions of these funds to support their Medicaid programs in 2011 and 2010, we cannot predict whether Congress will reallocate funds for 2012 and beyond. Additionally, the federal government has taken steps to address some of the insurance coverage challenges facing citizens by enacting the Children's Health Insurance Program Reauthorization Act of 2009, which expanded and extended the benefits available under BIPA, and extending the period of benefit coverage under the Consolidated Omnibus Budget Reconciliation Act, or COBRA, to unemployed individuals through the Economic Stimulus Bill.

We cannot predict what further action the federal government or the states may take under existing and future legislation to close budget gaps or reduce deficit spending.

#### *Impact of the Health Care Reform Act on Medicaid Reimbursement*

**Medicaid Coverage.** The Health Care Reform Act requires that by 2014 states expand Medicaid coverage to all individuals under age 65 with incomes up to 138% (after giving effect to a 5% "income disregard" provision) of the federal poverty level. The Health Care Reform Act requires states to, at a minimum, maintain Medicaid eligibility standards established prior to the enactment of the Health Care Reform Act for adults until January 1, 2014 and for children until October 1, 2019. However, states with budget deficits may seek exemptions from this requirement to address eligibility standards that apply to adults making more than 133% of the federal poverty level.

**Disproportionate Share Payments.** The Health Care Reform Act reduces funding for the Medicaid disproportionate share payment program for hospitals in federal fiscal years 2014 through 2020. How such cuts are allocated among the states and how the states allocate these cuts among providers have yet to be determined. Additionally, as part of the payroll tax cut extension that was signed into law on February 22, 2012, Medicaid disproportionate share payments will be reduced beginning in federal fiscal year 2021.

**Bundled Payment Pilot Programs.** The Health Care Reform Act provides for a five-year bundled payment pilot program for Medicaid services. HHS may select up to eight states to participate based on the potential to lower costs under the Medicaid program while improving care. As of December 31, 2011, two states are participating and at least two more states are pursuing legislation to allow their participation in the pilot program. State programs may target particular categories of beneficiaries, selected diagnoses or geographic regions of the state. The selected state programs will provide one payment for both hospital and physician services provided to Medicaid patients for certain episodes. The bundled payments may implicate existing laws, including the Anti-Kickback Statute, as defined below under "Fraud and Abuse Provisions," and the Health Insurance Portability and Accountability Act of 1996, or HIPAA, privacy, security and transaction standard requirements. However, the Health Care Reform Act does not authorize HHS to waive other laws that may impact the ability of hospitals and other eligible participants to participate in the pilot programs, such as antitrust laws.

#### *Medicare and Medicaid Regulatory and Audit Impacts*

In addition to legislative changes, such as those brought about by the Health Care Reform Act, Medicare and each of the state Medicaid programs are subject to regulatory changes, administrative rulings, interpretations and determinations, post-payment audits, requirements for utilization review and new government funding restrictions, all of which could materially increase or decrease payments we receive, impact our cost of patient care and affect the timing of payments. The final determination of amounts we receive under the Medicare and Medicaid programs often takes many years to resolve because of audits by the programs' representatives, providers' rights of appeal and the application of numerous technical reimbursement provisions. We believe that we have made adequate provisions for such potential adjustments. Nevertheless, until final adjustments are made, certain issues remain unresolved and our established allowances may be higher or lower than what is ultimately required.

The Medicare program utilizes a system of contracted carriers and fiscal intermediaries across the country to process claims and conduct post-payment audits. CMS is in the midst of an initiative to reform the carrier and fiscal intermediary functions. As part of such reform, CMS has and will continue to competitively bid the carrier and fiscal intermediary functions to Medicare Administrative Contractors, or MACs. At the present time, CMS has awarded all fifteen of the planned multi-state jurisdiction MAC contracts. Hospital operators have the option to either (i) have each of their hospitals work with the MAC in the jurisdiction where the individual hospital is located or (ii) use the MAC in the jurisdiction where their home office is located for all of their affiliated hospitals. Every year, each MAC is required to complete an Error Rate Reduction Program that includes initiatives to reduce and recover improper payments and may include more robust pre-payment and post-payment reviews for particular claim types. CMS also uses Zone Program Integrity Contractors to identify potential problem areas in coordination with their internal and external partners. The completed and future changes by CMS could affect claims processing, auditing and cash flow to Medicare providers. We cannot predict what, if any, impact such changes will ultimately have on our business.

The Health Care Reform Act increased federal funding for Medicaid Integrity Contractors, or MICs. MICs are private contractors that perform post-payment audits of Medicaid claims to identify overpayments. Through the Deficit Reduction Act of 2005, Congress expanded the federal government's involvement in fighting fraud, waste and abuse in the Medicaid program. MICs are currently assigned to five geographic regions and have commenced audits in several of the states assigned to those regions.

The Health Care Reform Act contains provisions relating to recovery audit contractors, or RACs, which are third party organizations under contract with CMS that identify underpayments and overpayments under the Medicare program and recoup overpayments on behalf of the government. The Health Care Reform Act expanded the RAC program's scope to include Medicaid claims and required all states to enter into contracts with RACs by December 31, 2010. If a state was unable to implement a RAC program by the implementation date of January 1, 2012, then the state was required to request an exception by submitting to CMS a revised State Plan Amendment, or SPA, through the normal SPA process. States have considerable flexibility regarding the design, procurement and operation of their individual RAC programs. RACs are paid a contingency fee based on the overpayments they identify and collect. We expect that RACs will look very closely at claims submitted by hospital operators in an attempt to identify possible overpayments.

#### ***Commercial Insurance and Other***

In recent years, a number of commercial insurers have undertaken efforts to limit the costs of hospital services by adopting prospective payment or DRG-based systems. To the extent that such efforts are successful and those insurers fail to reimburse hospitals for the costs of providing services to their beneficiaries, such efforts may have a negative impact on our business and results of operations.

We also provide services to individuals covered by private health insurance plans. Private insurance carriers typically reimburse a provider after the claim is filed; however, reimbursement can be sent directly to the patient based on the underlying insurance policy's stipulations. Reimbursement from private insurance carriers is often based on rates such as prospective payment systems, per diems or other discounted fee schedules. Private insurance reimbursement varies among payors and states and is generally based on contracts negotiated between the provider and the payor.

Additionally, we provide health care services to individuals covered under workers' compensation programs, TRICARE/CHAMPUS (for retired military personnel) and other private and government programs. Those programs pay under prospective payment systems, per-diem systems or other discounted fee systems.

Beginning in 2014, the Health Care Reform Act requires individuals to obtain, and employers to provide, health insurance coverage. Additionally, the law requires states to establish health insurance exchanges. The Health Care Reform Act also establishes a number of health insurance market reforms, including bans on lifetime limits and pre-existing condition exclusions, new benefit mandates and increased dependent coverage. By way of example, group health plans and health insurance issuers offering group or individual coverage:

- may not establish lifetime limits or, beginning in 2014, annual limits on the dollar value of benefits;
- may not rescind coverage of an enrollee, except in instances where the individual has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of a material fact;
- must reimburse hospitals for emergency services provided to enrollees without prior authorization and without regard to whether a participating provider contract is in place; and
- effective for health plan policy years that began on or after September 23, 2010 (for plans that offer dependent coverage), must continue to make dependent coverage available to unmarried dependents until age 26 (coverage for the dependents of unmarried adult children is not required).

We do not yet know what impact the abovementioned increased obligations on managed care payors and other payors will have on our ability to negotiate contracts with such payors.

### ***Self-Pay***

We provide services to individuals who have no form of health care insurance. These are the types of individuals for whom the Health Care Reform Act is intended to provide insurance coverage. Presently, these patients are evaluated at the time of service or shortly thereafter for their ability to pay based on federal and state poverty guidelines and/or qualifications for Medicaid or other state assistance programs, as well as our company-wide charity and indigent care policy. Gross charges to uninsured patients for non-elective procedures are discounted by 60% or more. Local hospital personnel and our collection agencies pursue payments on accounts receivable from self-pay patients who do not meet our charity and indigent care criteria.

A significant portion of our self-pay patients are admitted through, or treated in, our hospitals' emergency departments and often require high-acuity treatment. The Emergency Medical Treatment and Active Labor Act, or EMTALA, requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to a hospital's emergency room for treatment and, if the individual is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the individual to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of an individual's ability to pay for treatment. We believe that self-pay patient volume has been impacted during the last several years by a combination of broad economic factors, including high levels of unemployment and reductions in state Medicaid budgets, an increasing number of individuals and employers that choose not to purchase insurance and an increased co-payment and deductible burden that is borne by patients rather than insurers and/or employers.

The Health Care Reform Act requires health plans to reimburse hospitals for emergency services provided to enrollees without prior authorization and without regard to whether a participating provider contract is in place. The Health Care Reform Act also contains provisions that seek to decrease the number of uninsured individuals, including requirements that individuals obtain, and employers provide, health insurance coverage beginning in 2014. However, many factors are unknown regarding the impact of the Health Care Reform Act, including, among other things, how many previously uninsured individuals will take the steps necessary to obtain insurance coverage as a result of the new law. It is also unknown what change, if any, we will see in the volume of inpatient and outpatient services that are sought by and provided to previously uninsured individuals once they obtain insurance coverage. Moreover, it is difficult to predict the full impact of the Health Care Reform Act due to the law's complexity, lack of implementing regulations or interpretive guidance, gradual implementation, possible Congressional repeal or amendment and court challenges.

### ***Certain Other Aspects of the Health Care Reform Act***

**Whole Hospital Exception.** The Health Care Reform Act makes changes to the "whole hospital" exception under Section 1877 of the Social Security Act of 1935 (commonly known as the "Stark law"). Those changes effectively prohibit new physician-owned hospitals under the whole hospital exception and limit capacity expansion and the level of physician ownership at grandfathered physician-owned hospitals. As revised, the Stark law prohibits physicians from referring Medicare patients to a hospital in which they have an ownership or investment interest unless the hospital had physician ownership and a Medicare provider agreement in effect as of March 23, 2010 (or, for those hospitals under development, as of December 31, 2010). A physician-owned hospital that meets these requirements will still be subject to restrictions that limit the hospital's aggregate physician ownership percentage and, with certain narrow exceptions for high Medicaid utilization hospitals, prohibit expansion of the number of operating rooms, procedure rooms and licensed beds. The Health Care Reform Act also subjects physician-owned hospitals to reporting requirements and extensive disclosure requirements on the hospital's website and in any public advertisements. At December 31, 2011, we had joint ventures with physicians at 24 of our hospitals under the whole hospital exception of the Stark law and there were Medicare provider agreements in effect at all such hospitals. Those grandfathered joint venture hospitals are now subject to the physician ownership and expansion restrictions contained in the Health Care Reform Act.

**Accountable Care Organizations and Pilot Projects.** The Health Care Reform Act required HHS to establish a Medicare shared savings program that promotes accountability and coordination of care through the creation of Accountable Care Organizations, or ACOs. The shared savings program is intended to allow providers (including hospitals), physicians and other designated health care professionals and suppliers to form ACOs and voluntarily work together to invest in infrastructure and redesign delivery processes to achieve high quality and efficient delivery of services. The program is intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS will be eligible to share in a portion of the Medicare program's cost savings.

During October 2011, CMS released its final rules on ACOs, ostensibly making it easier for hospitals and physicians to participate in the program. In response to objections raised by the health care industry after release of proposed rules on March 31, 2011, CMS made several concessions in its final rules, including: (i) providers will be allowed to participate in an ACO and share in the cost savings with Medicare without the risk of losing money; (ii) ACOs will be able to start sharing in any cost savings earlier in the process, rather than having Medicare initially retain all such cost savings; (iii) the number of quality measures that ACOs will have to meet to qualify for performance bonuses was reduced from 65 to 33; (iv) at their formation, ACOs will be notified as to which Medicare beneficiaries are likely to be part of their system (under the proposed rules, ACOs would not know which patients were in the ACO until the end of each contract year); (v) community health centers and rural health clinics will be allowed to lead ACOs; and (vi) the timetable for the formation of an ACO was modified, with groups allowed to apply for start dates of January 1, 2012, April 1, 2012, July 1, 2012 or January 1, 2013. To entice providers to form ACOs, CMS stated that it will give physician-owned and rural providers early access to some of the expected savings, specifically \$170 million, so that they can have money available upfront to defray ACO start-up costs, including the development and implementation of electronic health records.

**Fraud and Abuse Provisions.** Medicare and Medicaid anti-kickback and anti-fraud and abuse laws, referred to as the Anti-Kickback Statute, prohibit certain business practices and relationships that might affect the provision and cost of health care services under the Medicare and Medicaid programs and other government programs, including the payment or receipt of remuneration for the referral of patients whose care will be paid for by such programs. The Health Care Reform Act provides that knowledge of the law or the intent to violate the law is not required and also provides that submission of a claim for services or items generated in violation of the Anti-Kickback Statute constitutes a false or fraudulent claim and may be subject to additional penalties under the federal False Claims Act of 1863. Sanctions for violating the Anti-Kickback Statute include criminal and civil penalties, as well as fines and possible exclusion from government programs, such as Medicare and Medicaid.

**Miscellaneous.** The Health Care Reform Act contains numerous other provisions that could affect our business and results of operations, including provisions relating to:

- the establishment of a Center for Medicare and Medicaid Innovation within CMS, which will have the authority to develop and test new reimbursement methodologies designed to improve the quality of patient care and lower costs;
- the creation of an Independent Payment Advisory Board that will make recommendations to Congress regarding additional changes to provider reimbursement methodologies and other aspects of the nation's health care system; and
- new taxes on manufacturers and distributors of pharmaceuticals and medical devices, as well as a requirement that manufacturers file annual reports of payments made to physicians.

#### **Utilization Review**

In accordance with the requirements of CMS' Services Conditions of Participation, hospital services provided to Medicare and Medicaid beneficiaries are evaluated to ensure that the care meets professionally recognized standards of practice and are medically necessary. Our hospitals are required to conduct utilization review activities, including medical necessity reviews (admission, continued stay and retrospective), discharge planning and quality improvement initiatives to address identified trends, extended lengths of stay and high cost cases. Additionally, many managed care organizations require utilization reviews.

#### **Compliance Program**

Our company-wide compliance program, which was first adopted in 1997, has been designed, implemented and maintained to deter, detect and prevent fraud, abuse and mistakes. We believe that our compliance program meets the standards of an effective compliance program as set forth in the compliance guidance for hospitals issued by the Office of the Inspector General of HHS, the standards of an effective compliance program as set forth in the U.S. Sentencing Commission Guidelines and the provisions of the Health Insurance Portability and Accountability Act, commonly referred to as HIPAA. We regularly review our compliance program and make changes from time to time and we continue to do so.

Our compliance program consists of an infrastructure that begins at the Board of Directors and executive management levels and runs through our centralized Compliance Office to all home office, divisional and facility operations. Our compliance program includes written guidance such as a Compliance Manual, a Code of Business Conduct and Ethics, and Compliance Policies and Procedures. Among other things, the Compliance Office has developed processes for: (i) the development and delivery of compliance training; (ii) anonymous and confidential reporting; (iii) investigating reported and suspected wrongdoing; (iv) assisting with the development and implementation of corrective actions; and (v) monitoring and auditing of compliance in high risk areas. When they

are initially hired and at least annually thereafter, all of our employees receive compliance training relating to these processes as well as our Compliance Manual, Code of Business Conduct and Ethics, and Compliance Policies and Procedures.

Day-to-day leadership of our compliance program is provided by our Vice President of Compliance who reports to our President and Chief Executive Officer and also reports, at least quarterly, to our Corporate Compliance Committee and our Board of Directors through the Audit Committee. At the operational level, each hospital has a designated and trained hospital compliance officer who reports on compliance matters to a divisional compliance officer, who ultimately reports to our Vice President of Compliance.

#### **Employees and Medical Staff**

As of December 31, 2011, we had approximately 40,600 employees, including 8,600 part-time employees. At such date, 1,224 of our employees were covered by collective bargaining agreements. We believe that our employee relations are satisfactory.

Physicians on the medical staffs of our hospitals are, in most cases, not our employees. Such non-employee physicians may also be staff members of other hospitals. As of December 31, 2011, we employed approximately 900 physicians, about half of whom are primary care physicians at practices we own and operate. Additionally, our hospitals provide emergency room, radiology, pathology and anesthesiology services through service contracts with physician groups that are generally cancelable with 90 days advance notice.

#### **Professional Liability and Other Risks**

As is typical in the health care industry, we are subject to claims and legal actions by patients and others in the ordinary course of business. We use our wholly owned captive insurance subsidiary and our risk retention group subsidiary, which are domiciled in the Cayman Islands and South Carolina, respectively, to self-insure a significant portion of our professional liability risks. Those subsidiaries provide (i) claims-made insurance coverage to all of our hospitals and other health care facilities and (ii) occurrence-basis coverage to most of our employed physicians. The employed physicians not covered by our insurance company subsidiaries generally maintain claims-made policies with unrelated third party insurance companies. To mitigate the exposure of the self-insured program covering the hospitals and other health care facilities, our insurance company subsidiaries buy claims-made reinsurance policies from unrelated third parties for claims above certain self-retention levels.

We also maintain directors' and officers', property and other typical insurance policies with commercial carriers, subject to self-insurance retention levels. We believe that our insurance is adequate in amount and coverage. However, in the future, insurance may not be available at reasonable prices or we may have to increase our self-insurance retention levels.

#### **Environmental Regulation**

We are subject to compliance with various federal, state and local environmental laws, rules and regulations, including, but not limited to, the disposal of medical waste generated by our hospitals and other health care facilities. Our environmental compliance costs are not significant and we do not anticipate that they will be significant in the future.

#### **Seasonality**

We typically experience higher patient volume and net revenue in the first and fourth quarters of each calendar year because, generally, more people become ill during the winter months, which in turn increases the number of patients that we treat during those months.

#### **Available Information**

We are subject to the informational requirements of the Securities Exchange Act of 1934. Therefore, we file periodic reports, proxy statements and other information with the Securities and Exchange Commission (the "SEC"). Such reports may be read and copied at the SEC's Public Reference Room at 100 F Street NE, Washington, D.C. 20549. Information regarding the operation of the Public Reference Room may be obtained by calling the SEC at (800) SEC-0330. The SEC also maintains a website ([www.sec.gov](http://www.sec.gov)) that includes our reports, proxy statements and other information.

We maintain a website at [www.hma.com](http://www.hma.com) where we make available, free of charge, documents that we file with, or furnish to, the SEC, including our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, proxy statements and any amendments to those reports. We make this information available as soon as reasonably practicable after we electronically file such materials with, or furnish such information to, the SEC. Our SEC reports can be found under "Investor Relations" on our website. The other information found on our website is not part of this or any other report we file with, or furnish to, the SEC.

## Item 1A. Risk Factors.

Our business and operations are subject to numerous risks, many of which are described below and elsewhere in this Annual Report on Form 10-K, including those under “Business” in Item 1 and “Management’s Discussion and Analysis of Financial Condition and Results of Operations” in Item 7 of Part II. The risks described therein and elsewhere in this report are incorporated into this Item 1A by reference.

If any of the events described below occur, our business and results of operations could be harmed. Additional risks and uncertainties that are not presently known to us, or which we currently deem to be immaterial, could also harm our business and results of operations.

***We are subject to extensive government regulation regarding the conduct of our operations. If we fail to comply with any existing or new laws or regulations, we could suffer administrative, civil or criminal penalties or be required to make significant changes to our operations.***

Companies such as ours that provide health care services are required to comply with many highly complex laws and regulations at the federal, state and local levels, including, but not limited to, those relating to the adequacy of medical care, billing for services, patient privacy, equipment, personnel, operating policies and procedures and maintenance of records. Our policy is to comply with all applicable laws and regulations; however, if we fail to comply with any such laws or regulations, we could become subject to civil and criminal penalties, including the loss of licenses to operate our facilities. We could also be excluded from participating in Medicare, Medicaid and other federal and state health care programs that contribute significantly to our revenue.

Many of the laws and regulations that govern our operations are highly complex and, in certain cases, we do not have the benefit of regulatory or judicial interpretation. In the future, it is possible that different interpretations or enforcement of such laws and regulations, as well as modifications thereof, could require us to make changes in our facilities, equipment, personnel, services or capital expenditure programs. Any such changes could harm our business and results of operations.

***We are unable to predict the impact that the Health Care Reform Act, which will significantly change the health care industry, will have on our business and results of operations.***

The Health Care Reform Act will dramatically change how health care services are covered, delivered and reimbursed through, among other things: a requirement that most Americans obtain health insurance; expanded Medicaid eligibility and coverage for uninsured individuals; reduced growth in Medicare program spending; reductions in Medicare and Medicaid payments; the establishment of value-based purchasing programs where reimbursement is tied to quality; and the elimination of the ability of health care providers like us to enter into new partnerships with physicians in the ownership of certain health care facilities. Additionally, the Health Care Reform Act contains provisions designed to strengthen fraud and abuse enforcement, modifies the health insurance industry and expands existing efforts to tie Medicare and Medicaid reimbursement to performance and quality.

We believe that the expansion of health insurance coverage under the Health Care Reform Act could increase the number of patients using our facilities who have either private or public program health care coverage. As a result of the increased income eligibility limits under the law, we believe that a large percentage of the new Medicaid coverage will be in states that currently have relatively low income eligibility requirements. Three such states are Florida, Mississippi and Tennessee where we operated 42 hospitals as of December 31, 2011. It is difficult to predict the impact of changes resulting from the Health Care Reform Act on us because of numerous issues surrounding the implementation of such law, including, but not limited to, uncertainty regarding:

- the possibility that portions of the Health Care Reform Act, such as those expanding health insurance or Medicaid coverage, will be delayed or blocked due to court challenges, or revised or repealed as a result of legislative action, including an appeal currently pending before the United States Supreme Court that will determine the constitutionality of the Health Care Reform Act (a ruling is expected by July 2012);
- how many previously uninsured individuals will obtain coverage;
- what percent of newly insured patients will be covered under Medicaid or private health insurance programs;
- the pace at which health care insurance coverage expands;
- the change, if any, in the volume of inpatient and outpatient hospital services that are sought by and provided to previously uninsured individuals;
- changes in rates paid to hospitals by private payors;
- changes in rates paid by state governments under the Medicaid program;
- the ability of states to fund their portion of Medicaid payments;
- the extent to which states will enroll new Medicaid participants in managed care programs;

- how the performance and quality programs mandated by the Health Care Reform Act will be implemented; and
- whether the Health Care Reform Act will ultimately cause health insurers to seek to reduce reimbursement payments.

The Health Care Reform Act also provides for significant reductions in the growth of Medicare spending, reductions in Medicare and Medicaid payments and the establishment of value-based purchasing programs. It is possible that these changes could more than offset other favorable effects from the Health Care Reform Act. It is difficult to predict the impact of the potentially adverse changes on us because of a number of factors, including, but not limited to, uncertainty regarding:

- whether reductions required by the Health Care Reform Act will be modified prior to becoming effective;
- the revenue we will generate from Medicare and Medicaid business when the various reductions and adjustments planned under the Health Care Reform Act are implemented;
- whether the Health Care Reform Act's performance and quality initiatives will have a negative impact on our business;
- how successful "Accountable Care Organizations" in which we may participate will be at coordinating care and reducing costs;
- changes to revenue as a result of value-based purchasing;
- changes to revenue as a result of bundled payment programs;
- the scope and nature of potential changes to Medicare reimbursement methods; and
- reductions in payments we might receive from Medicare for "excessive readmissions" or "hospital acquired conditions."

As summarized above and elsewhere in these risk factors, we cannot predict the full impact of the Health Care Reform Act on our business or results of operations because of, among other things: (i) the law's complexity; (ii) the lack of implementing regulations and/or interpretive guidance; (iii) the timing of the law's implementation (and possible delays in such implementation); (iv) pending and future legal challenges that seek to delay or block certain of the law's provisions; and (v) possible legislative amendment or repeal of the law. Additionally, we cannot predict how individuals and businesses will respond to the new mandates and alternatives established under the Health Care Reform Act.

***We are subject to "anti-kickback" and "self-referral" laws and regulations that provide for criminal and civil penalties if they are violated.***

The health care industry is subject to many laws and regulations that are designed to deter and prevent practices deemed by the government to be fraudulent, abusive or otherwise contrary to government policies. Unless a safe harbor applies, federal and state anti-kickback laws prohibit giving or receiving any consideration in return for physician referrals. Similarly, unless an exception applies, Section 1877 of the Social Security Act of 1935 (commonly known as the "Stark law") prohibits physicians from referring Medicare and Medicaid patients to providers of enumerated "designated health services" with whom the physician or a member of the physician's immediate family has an ownership interest or compensation arrangement. Such referrals are deemed to be "self-referrals" due to the physician's financial relationship with the entity providing the designated health services. Moreover, many states have adopted or are considering similar legislative proposals, some of which extend beyond the scope of the Stark law to prohibit the payment or receipt of remuneration for the prohibited referral of patients for designated health care services and physician self-referrals, regardless of the source of payment for the patient's care. The Health Care Reform Act provides that submission of a claim for services generated or items provided in violation of the Stark law constitutes a false or fraudulent claim that may be subject to additional penalties under the federal False Claims Act of 1863, referred to as the False Claims Act.

The Health Care Reform Act provides greater resources to enforce the Stark law, including supplemental federal funding of \$350 million over ten years to fight health care fraud, waste and abuse. The Health Care Reform Act also changes the intent requirement for health care fraud such that a person need not have actual knowledge or specific intent to commit a violation of the law. This change in the intent requirement will likely make it easier for fraud claims to be brought against a health care provider.

We systematically review our operations on a regular basis to monitor compliance with anti-kickback laws, the Stark law and similar state statutes. When evaluating collaborative relationships with physicians, we consider the scope and effect of these statutes and seek to structure the arrangements in full compliance with their provisions. We also maintain a company-wide compliance program to monitor and promote our continued compliance with these and other statutory prohibitions and requirements. Nevertheless, if it is determined that any of our practices or operations violate the anti-kickback laws, the Stark law or similar state statutes, we could become subject to civil

and criminal penalties, including exclusion from Medicare, Medicaid and other federal and state health care programs that contribute significantly to our revenue. The imposition of penalties for alleged or actual violations of the anti-kickback laws, the Stark law and/or similar state statutes, our inability to comply with changes in such laws and/or significant compliance costs associated with any modified laws and regulations could each harm our business.

Additionally, the anti-kickback laws, the Stark law and similar state statutes are subject to change and interpretations and we may not be able to comply with the modified laws and regulations. Moreover, our continued compliance with any such modified laws and regulations could require us to devote extensive resources, financial and otherwise, to achieving and maintaining compliance.

***Providers in the hospital industry have been the subject of federal and state investigations and we could become subject to such investigations or whistleblower lawsuits in the future.***

Historically, significant media and public attention has been focused on the hospital industry due to investigations related to referrals, cost reporting and billing practices, laboratory and home health care services and physician ownership of joint ventures involving hospitals. Federal and state government agencies have heightened and coordinated their civil and criminal enforcement efforts. Additionally, the Office of the Inspector General of HHS ("HHS-OIG") and the U.S. Department of Justice have, from time to time, established enforcement initiatives that focus on specific areas of suspected fraud and abuse. Recent and recently announced initiatives have focused on hospital billing practices (e.g., kyphoplasty, implantable cardioverter defibrillators, or ICDs, etc.), health care provider bad debts, disproportionate share payments, reliability of hospital-reported quality measure data, compliance with the Emergency Medical Treatment and Active Labor Act of 1986, MS-DRG coding and serious medical errors.

In March 2005, CMS began implementing a pilot recovery audit contractor program, known as RAC, which covered health care providers in certain states. The Tax Relief and Health Care Act of 2006 made the RAC program permanent and expanded it to all fifty states. Among other things, RAC auditors, who are independent contractors, focus on the clinical documentation supporting billings under the Medicare program. If an auditor concludes that such documentation does not support the provider's Medicare billings, CMS will revise the amount due to the provider, compare such amount to what was previously paid and withhold the difference from a current remittance. The affected facility can appeal the auditor's findings through an administrative process. During federal fiscal year 2011, approximately \$797.4 million in overpayments to Medicare providers was identified and collected and \$141.9 million in underpayments was returned to Medicare providers under the RAC program. Effective January 1, 2012, a new three-year Recovery Audit Prepayment Review Demonstration was implemented by CMS, which will allow RAC auditors to conduct prepayment claim reviews. CMS believes such prepayment reviews will both assist in lowering the improper payment rate and identifying potential fraud and abuse, as opposed to the traditional post-payment review mechanisms.

The Health Care Reform Act expanded the RAC program's scope to all of Medicare, including managed Medicare plans and Medicaid claims, and required all states to enter into contracts with RACs by December 31, 2010. If a state was unable to implement a RAC program by the implementation date of January 1, 2012, then the state was required to request an exception by submitting to CMS a revised State Plan Amendment. The Health Care Reform Act also increased federal funding for Medicaid Integrity Contractors (private contractors that perform post-payment audits of Medicaid claims) for federal fiscal year 2011 and beyond. Additionally, several other contractors, including state Medicaid agencies, have increased their audit and review activities.

The federal government may investigate and bring suit under the False Claims Act. Additionally, the False Claims Act permits private individuals to bring qui tam lawsuits, or "whistleblower" actions, against companies on behalf of the government, alleging that a hospital or health care provider has defrauded a federal or state government program, such as Medicare or Medicaid. As discussed under "Legal Proceedings" in Item 3 and Note 13 to the Consolidated Financial Statements in Item 8 of Part II, we have been named, and may be named, in qui tam actions. Because qui tam lawsuits are filed under seal, we could be named in other such lawsuits of which we are not aware. Additionally, as further discussed under "Legal Proceedings" in Item 3 and Note 13 to the Consolidated Financial Statements in Item 8 of Part II, we are subject to government False Claims Act investigations. If the government intervenes in a qui tam action, or brings its own False Claims Act action after an investigation, and prevails, the defendant may be required to pay three times the actual damages sustained by the government, plus mandatory civil penalties of between \$5,500 and \$11,000 for each separate false claim. Typically, each false bill submitted by a health care provider to the government is considered a separate false claim and, therefore, penalties under the False Claims Act can be substantial. If the government does not intervene in an action, the qui tam plaintiff may continue to pursue the action independently and the government may seek leave to intervene in the action later in the proceedings. As part of the resolution of a qui tam case, the party filing the initial complaint may share in a portion of any settlement or judgment.

There are many potential bases for liability under the False Claims Act. Liability often arises when an entity "knowingly" submits a false claim for reimbursement to the federal government. The False Claims Act defines the term "knowingly" broadly. Though simple negligence will not give rise to liability under the False Claims Act, submitting a claim with reckless disregard to its truth or falsity constitutes a "knowing" submission under the False Claims Act and, therefore, will qualify for liability. The Fraud Enforcement and Recovery Act of 2009 expanded the scope of the False Claims Act by, among other things, creating liability for knowingly and improperly avoiding repayment of an overpayment received from the government and broadening protections for whistleblowers. Under the Health Care Reform Act, the knowing failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later, constitutes a violation of the False Claims Act. Thus, if a provider is aware that it has retained an overpayment that it has an obligation to refund, there may be a basis for a False Claims Act violation even if the provider did not know the claim was "false" when it was submitted. Further, the Health Care Reform Act expands the scope of the False Claims Act to cover payments in connection with the new health insurance exchanges to be created by the law, if those payments include any federal funds.

The Health Care Reform Act also significantly changes the False Claims Act by removing the jurisdictional bar for allegations based on publicly disclosed information and reducing the requirements for a qui tam relator to qualify as an "original source." These changes may increase the False Claims Act exposure for health care providers by enabling a greater number of whistleblowers to bring claims.

We closely monitor our billing and other health care practices to maintain compliance with prevailing industry interpretations of applicable laws and regulations. As further discussed under "Legal Proceedings" in Item 3 and Note 13 to the Consolidated Financial Statements in Item 8 of Part II, we are investigating our compliance in the areas that we believe are the subject of the government investigations, and have undertaken a review of our compliance program. Moreover, government investigations could be initiated that are inconsistent with industry practices and prevailing interpretations of existing laws and regulations. In public statements, government authorities have from time to time taken positions on issues for which little official interpretation was available. Some of those positions appear to be inconsistent with practices that have been common within our industry and, in some cases, have not been challenged. Additionally, some government investigations that were previously conducted under civil provisions of federal law are now being conducted as criminal investigations under fraud and abuse laws and certain government investigations that were previously handled administratively are now being conducted as either civil or criminal investigations under civil and criminal fraud and abuse laws.

We cannot predict the outcome of existing government investigations and qui tam lawsuits or whether we will be the subject of future government investigations, inquiries or whistleblower lawsuits. Any determination that we have violated applicable laws or regulations or even a public announcement that we are being investigated for possible violations could harm our business and results of operations. Government investigations, as well as qui tam lawsuits, may lead to material fines, penalties, damages payments or other sanctions, including exclusion from government health care programs. Settlements of lawsuits involving Medicare and Medicaid issues routinely require monetary payments, which could have a materially adverse effect on our business, financial condition, results of operations and/or cash flows.

Additionally, HHS-OIG regularly negotiates corporate integrity agreements, or CIAs, with health care providers as part of the settlement of federal health care program investigations arising under the False Claims Act and other laws. HHS-OIG has the power to exclude providers from federal health care programs and often threatens to exercise that power unless a provider agrees to the terms of a CIA. Although each CIA is different, there are some common provisions. For instance, a CIA generally lasts five years, requires the implementation of specified HHS-OIG compliance policies and procedures and mandates the retention of an independent review organization that is authorized to conduct reviews of the provider. If we were to enter into a CIA as part of a settlement with HHS-OIG in connection with any existing or future proceeding, these and other terms of a CIA could have a materially adverse effect on our business, financial condition, results of operations and/or cash flows.

***We could fail to comply with laws and regulations regarding patient privacy and patient information security that could subject us to civil and criminal penalties or harm our results of operations.***

There have been numerous legislative and regulatory initiatives at the federal and state levels addressing patient privacy and security standards related to patient information. In particular, federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, or HIPAA, contain provisions that required us to implement and, in the future, may require us to implement additional costly electronic media security systems and to adopt new business practices designed to protect the privacy and security of each of our patient's health and related financial information. Such privacy and security regulations impose extensive administrative, physical and technical requirements on us, restrict our use and disclosure of certain patient health and financial information, provide patients with rights with respect to their health information and require us to enter into contracts extending many of the privacy and security regulatory requirements to third parties that perform duties and services on our behalf. We

are also required to make certain expenditures to help ensure our continued compliance with such laws and regulations and, in the future, such expenses could negatively impact our results of operations. The American Recovery and Reinvestment Act of 2009, referred to as the Economic Stimulus Act, included provisions for heightened enforcement of HIPAA and stiffer penalties for HIPAA violations. If we violate or fail to comply with any such laws or regulations, we could be subject to civil and criminal penalties or it might be necessary for us to increase the personnel, financial and technological resources we devote to our operations to achieve compliance. Moreover, a violation or failure to comply with any such laws or regulations could cause harm to our reputation which, in turn, could result in our patients seeking health care services at facilities that are not operated by us. If any of the foregoing events were to occur, our business and results of operations could be harmed.

***If any of our existing health care facilities lose their accreditation or any of our new facilities fail to receive accreditation, such facilities could become ineligible to receive reimbursement under the Medicare, Medicaid and other federal and state health programs, which could harm our business and adversely affect our results of operations.***

The construction and operation of health care facilities are subject to extensive federal, state and local regulation relating to, among other things, the adequacy of medical care, equipment, personnel, operating policies and procedures, fire prevention, rate-setting and compliance with building codes and environmental protection. Additionally, such facilities are subject to periodic inspection by government authorities to assure their continued compliance with the relevant standards.

All of our hospitals (and substantially all of our laboratories, home health agencies and other health care facilities) are accredited, meaning that they are properly licensed under the relevant state laws and regulations and certified under the Medicare program. The effect of maintaining accredited facilities is to allow such facilities to participate in the Medicare and Medicaid programs. Should any of our health care facilities lose their accredited status and thereby lose certification under the Medicare or Medicaid programs, such facilities would be unable to receive reimbursement from either of those programs and our business and results of operations could be harmed. Because the requirements for accreditation are subject to modification, it may be necessary for us to affect changes in our facilities, equipment, personnel and services to maintain accreditation. Such changes could be expensive and could adversely affect our results of operations.

***State efforts to regulate the construction or expansion of health care facilities could impair our ability to expand.***

The construction of new health care facilities, the acquisition of existing health care facilities and the addition of new beds or services at existing health care facilities may be reviewed by state regulatory agencies under certificate of need and similar laws. Except for Arkansas, Oklahoma, Pennsylvania and Texas, all other states where our hospitals operate have certificate of need or similar laws. Such laws generally require state agency determination of public need and local agency approval prior to the construction of a new hospital facility and/or the addition of new beds or significant services to a hospital, or a related capital expenditure. Failure to obtain the necessary approvals in these states could: (i) result in our inability to complete a particular hospital acquisition, expansion or replacement; (ii) make a facility ineligible to receive reimbursement under the Medicare and/or Medicaid programs; (iii) result in the revocation of a facility's license; or (iv) impose civil and criminal penalties on us, any of which could harm our business and results of operations.

***Our operations are subject to occupational health, safety and other similar regulations and failure to comply with such regulations could harm our business and results of operations.***

We are subject to a wide variety of federal, state and local occupational health and safety laws and regulations. Regulatory requirements affecting us include, but are not limited to, those covering: (i) air and water quality control; (ii) occupational health and safety (e.g., standards regarding blood-borne pathogens and ergonomics, etc.); (iii) waste management; (iv) the handling of asbestos, polychlorinated biphenyls and radioactive substances; and (v) other hazardous materials. If we fail to comply with those standards, we may be subject to sanctions and penalties that could harm our business and results of operations.

***We could fail to comply with the federal Emergency Medical Treatment and Active Labor Act of 1986, or EMTALA, which could subject us to civil monetary penalties or cause us to be excluded from participation in the Medicare program.***

All of our facilities are subject to EMTALA, which requires every hospital participating in the Medicare program to conduct a medical screening examination of each person presented for treatment at its emergency room. If a patient is in active labor or suffering from an emergency medical condition, the hospital must either stabilize that condition or make an appropriate transfer of the patient to a facility that can handle the condition, regardless of

the patient's ability to pay for care. EMTALA imposes severe penalties if a hospital fails to screen, appropriately stabilize or transfer a patient, or if a hospital delays service while first inquiring about the patient's ability to pay. Such penalties include, but are not limited to, civil monetary penalties and exclusion from participation in the Medicare program. In addition to civil monetary penalties, an aggrieved patient, a patient's family or a medical facility that ultimately suffers a financial loss as a direct result of a transferring hospital's EMTALA violation can commence a civil suit under EMTALA. Although we believe that our facilities comply with EMTALA, there can be no assurances that claims will not be brought against us and, if successfully asserted against one or more of our hospitals, such claims could adversely affect our business and results of operations.

***Increased state regulation of the rates we charge for our services could adversely affect our results of operations.***

We currently operate one hospital in West Virginia, a state that requires us to submit annual requests for increases in our rates. Accordingly, the operating margins for our West Virginia hospital may be adversely affected if we are unable to increase our rates as our expenses increase, or if the rates we charge are decreased as a result of regulatory action. If other states in which we operate enact similar rate-setting laws, those actions could harm our business and results of operations.

***Continued weak economic conditions could adversely impact our business and results of operations.***

Our future patient volume, the ability to collect our accounts receivable and our overall future results of operations could be materially adversely impacted by a continuation of the current weak economic conditions, especially levels of unemployment that are substantially higher than historical trends. While certain health care spending is considered non-discretionary and may not be significantly impacted by economic downturns, other types of health care spending may be adversely impacted by these conditions. When individuals are experiencing personal financial difficulties or have concerns about general economic conditions, they may choose to defer or forego elective surgeries and other non-emergent procedures, which are generally more profitable lines of business for hospitals. Moreover, a greater number of uninsured patients may seek care in our emergency rooms. We believe that a persistent weak economy could: (i) increase the number of uninsured people, which would likely increase our costs for uncompensated patient care; (ii) reduce our revenue due to decreased funding from Medicaid and other state health care programs that are struggling financially; (iii) reduce the number of elective surgeries and other procedures performed at our hospitals and other health care facilities; and (iv) threaten the solvency of managed care health plans and others that do business with us, each of which could adversely impact our business and results of operations.

***Growth in the number of uninsured and underinsured patients or deterioration in the collectability of the accounts of such patients could adversely affect our results of operations.***

The principal collection risks for our accounts receivable relate to uninsured patient accounts and patient accounts for which the primary insurance carrier has paid the amounts required by the applicable agreement but patient responsibility amounts (e.g., deductibles, co-payments, other amounts not covered by insurance, etc.) remain outstanding. Our provision for doubtful accounts provides for, among other things, amounts due from such patients. The determination of the amount of our provision for doubtful accounts is based on, among other things, our assessment of historical cash collections and accounts receivable write-offs, expected net collections, business and economic conditions, trends in federal, state and private employer health care coverage and other relevant key indicators. If we experience significant increases in uninsured and underinsured patients and/or uncollectible accounts receivable, our results of operations could be adversely affected.

In accordance with our Code of Business Conduct and Ethics, as well as the provisions of EMTALA, we provide a medical screening examination to any individual who comes to one of our hospitals while in active labor and/or seeking medical treatment (whether or not such individual is eligible for insurance benefits and regardless of ability to pay) to determine if such individual has an emergency medical condition. If it is determined that such person has an emergency medical condition, we provide further medical treatment as is required to stabilize the patient's medical condition, within the facility's capability, or arrange for the transfer of such patient to another medical facility in accordance with applicable law and the treating hospital's written procedures. If our volume of indigent and charity care patients with emergency medical conditions increases significantly, our results of operations may be adversely impacted.

The Health Care Reform Act seeks to decrease, over time, the uninsured population. Among other things, the Health Care Reform Act will, effective January 1, 2014, expand Medicaid eligibility and incentivize employers to offer, and require individuals to carry, health insurance or be subject to penalties. Even after full implementation of the Health Care Reform Act, we may continue to experience a high level of uncollectible accounts and provide discounts to, and charity care for, certain individuals who are not enrolled in a health care program under the law.

***If government programs or managed care companies reduce the payments we receive as reimbursement for the health care services we provide, whether as a result of the implementation of the Health Care Reform Act or otherwise, our revenue could decline and our business and results of operations could be adversely affected.***

We derive a substantial portion of our revenue from federal and state government reimbursement programs, including Medicare and Medicaid. Such programs are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations concerning, among other things: (i) patient eligibility requirements and the method of calculating payments or reimbursement; (ii) requirements for utilization review activities; and (iii) federal and state funding restrictions, all of which could materially increase or decrease the payments to us in the future, as well as affect the timing of such payments.

Previous changes in the Medicare and Medicaid programs have resulted in limitations on reimbursement and, in some cases, reduced levels of reimbursement for health care services. Specifically, the Health Care Reform Act provides for significant reductions in the growth of Medicare program spending, including reductions in market basket update factors and disproportionate share payments. Reductions to our Medicare and Medicaid reimbursement by the Health Care Reform Act could harm our business and adversely impact our results of operations, especially in the short-term before we experience any potential increases in revenue from providing care to previously uninsured individuals.

Pressure on federal and state programs, which has increased as a result of the prolonged economic downturn, may also impact the availability of taxpayer funds for the Medicare and Medicaid programs. For example, a number of states are experiencing substantial budget shortfalls and, as a result, have adopted legislation, or are considering legislation, designed to reduce their Medicaid expenditures and/or reduce the number of Medicaid enrollees. We are unable to predict the potential effects that future government health care funding policy changes will have on our operations. Moreover, in response to the Health Care Reform Act and state budgetary fiscal pressures, many states are seeking waivers and demonstration program approval from CMS with respect to their Medicaid programs. The proposals are varied and include, among other things, features such as mandatory managed care, capitated managed care and a prioritized list of health care services to define a state program's benefit package. We cannot predict which, if any, of these or other waivers and demonstrations will be permitted within the states where we operate. If the rates paid by government payors are reduced or if the scope of services covered by government payors is limited, our business and results of operations could be adversely affected.

In addition to changes in government reimbursement programs, third party payors, including managed care health plans, are increasingly demanding discounted fee structures or the assumption by health care providers of all or a portion of the financial risk through, among other means, capitation arrangements under which health care providers are paid a fixed fee per enrolled participant, regardless of the level of services provided to that participant. Efforts by third parties to aggressively manage reimbursement levels and enforce stringent cost controls are expected to continue. In fact, as the Health Care Reform Act is implemented over time, third party payors may increasingly demand reduced fees. Our future success will depend, in part, on our ability to retain and renew our managed care contracts and enter into new managed care contracts on terms that are favorable to us. It would harm our business if we were unable to enter into arrangements with managed care health plans on economic terms that are acceptable to us. Material reductions in the payments that we receive for our services or difficulties collecting our accounts receivable from managed care health plans could each adversely affect our business and results of operations.

***If unfavorable Medicare or Medicaid reimbursement changes result from the Budget Control Act of 2011, our business and results of operations could be harmed.***

The Budget Control Act of 2011, or the BCA, was enacted on August 2, 2011. Among other things, the BCA (i) increased the federal debt ceiling by approximately \$900 billion and (ii) immediately cut and capped federal discretionary spending, excluding the Medicare and Medicaid programs, thereby saving an estimated \$917 billion over the next ten years. The BCA also established the Joint Select Committee on Deficit Reduction (the "Deficit Reduction Committee"), a twelve-member bipartisan joint committee of Congress. The primary goal of the Deficit Reduction Committee was to propose legislation by November 23, 2011 to further reduce the federal deficit by \$1.5 trillion over the next ten years. Those deficit reduction measures were expected to be in addition to those already contained in the Health Care Reform Act. Pursuant to the BCA, if the legislation proposed by the Deficit Reduction Committee was not approved by Congress by December 23, 2011 and enacted into law by January 15, 2012 or if the Congressionally approved legislation did not achieve a federal deficit reduction in an amount of at least \$1.2 trillion, then spending cuts aggregating \$1.2 trillion over the next ten years (less any amount that resulted from earlier Congressional action) would automatically begin in January 2013. The Deficit Reduction Committee failed to propose legislation by December 23, 2011. Therefore, the reductions and spending cuts dictated by the BCA, which are required to be split equally between defense and non-defense programs, are scheduled to take effect beginning in

January 2013. Payments to Medicare providers are included in the automatic spending cuts; however, the BCA provides that Medicare payments may be reduced by no more than 2% and certain other programs, including Medicaid, would be exempt from the automatic spending cuts. At this time, we are unable to determine how the automatic Congressional spending cuts will affect Medicare and Medicaid reimbursement in the future; however, significant reimbursement reductions or other program modifications that result from the BCA could harm our business and results of operations.

***Controls designed by third parties to reduce inpatient services may reduce our revenue.***

Controls imposed by third party payors that are designed to reduce admissions and average length of hospital stays, commonly referred to as "utilization reviews," have affected and are expected to continue to affect our operations. Utilization reviews entail an evaluation of a patient's admission and course of treatment by managed care health plans. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively impacted by payor-required pre-admission authorization, utilization reviews and payor pressure to maximize outpatient and alternative health care delivery services for less acutely ill patients. Efforts to impose stringent cost controls are expected to continue. For example, the Health Care Reform Act expands the use of prepayment and postpayment reviews by Medicare and Medicaid contractors. Although we cannot predict the effect that these changes will have on our operations, limitations on the scope of services for which we are reimbursed and/or downward pressure on reimbursement rates and fees as a result of utilization reviews could adversely affect our results of operations.

***Our substantial borrowings have, and will continue to have, a significant effect on our business and may affect our ability to secure additional financing when needed.***

As of December 31, 2011, we had approximately \$3.6 billion of long-term debt and capital lease obligations, as well as availability of \$400.3 million under a long-term revolving credit facility. Our ability to service, repay or refinance our indebtedness or secure additional capital resources to fund our operational, acquisition and other growth strategies will depend on, among other things, our future operating performance. Those operating results may be affected by general economic, competitive, regulatory, business and other factors beyond our control. We believe that our future cash flow from operating activities, together with currently available and potentially new financing arrangements, will be sufficient to fund our operating, strategic growth, capital expenditure and debt service requirements. However, if we fail to meet our financial obligations or if supplemental financing is not available to us on satisfactory terms when needed, our business could be harmed.

Our substantial leverage, debt service requirements and covenant restrictions/limitations could have other important consequences to us, including, but not limited to, the following:

- Our senior secured credit facilities, which are described at Note 2 to the Consolidated Financial Statements in Item 8 of Part II, and the indentures governing our senior notes and our convertible senior subordinated notes contain, and any future debt obligations that we incur will likely contain, covenants and restrictions that, among other things, require us to maintain compliance with certain financial ratios. If we do not comply with these or other financial covenants in those arrangements, an event of default may result, which, if not cured or waived, could require us to immediately repay or refinance our indebtedness. Additionally, an event of default under our senior secured credit facilities would permit the lenders to terminate all commitments to extend further credit to us under such facility. Furthermore, if we become unable to repay the amounts due and payable under our senior secured credit facilities, the lenders could proceed against the collateral granted to them to secure that indebtedness. In the event that our lenders accelerate the repayment of our borrowings, we may not have sufficient assets to repay that indebtedness. Moreover, covenant violations could also subject us to higher interest and financing costs on our debt obligations and our credit ratings could be adversely affected.
- In the event of a default under one or more of our debt arrangements, we may be forced to pursue alternative strategies, such as restructuring or refinancing our indebtedness, selling core assets, reducing or delaying capital expenditures or seeking additional equity capital. There can be no assurances that any of these strategies could be effectuated on satisfactory terms, if at all, or that sufficient funds could be obtained to make required debt service payments. Additionally, a debt restructuring could subject us to higher interest and financing costs and our credit ratings could be adversely affected.
- In the event of higher interest rates in the marketplace or if we fail to timely register certain of our debt with the Securities and Exchange Commission, as described at Note 2(b) to the Consolidated Financial Statements in Item 8 of Part II, we could be exposed to higher interest and financing costs on our variable rate long-term borrowings.

- We are required to dedicate a substantial portion of our cash flow to the payment of principal and interest on our indebtedness, which may reduce the amount of discretionary funds available for our other operational needs and growth objectives.
- Because of the need for increased cash flow to service our debt arrangements, we may be more vulnerable to a decline in our business, changes in the health care industry or prolonged weak economic conditions.
- Our flexibility in planning for, or reacting to, changes in our business and the health care industry may be limited.
- We may be at a disadvantage in the markets where our hospitals and other health care facilities operate when compared to our competitors and peers that have less debt or less restrictive covenants.
- We may be limited in our ability to obtain financing in the future for working capital, capital expenditures, acquisitions or other purposes on acceptable terms on a timely basis, or at all.

***The terms of our senior secured credit facilities and the indentures governing our senior notes and our convertible senior subordinated notes restrict our current and future operations, particularly our ability to take certain actions, which could harm our business.***

Our senior secured credit facilities and the indentures governing our senior notes and our convertible senior subordinated notes contain a number of restrictive covenants that impose significant operational and financial restrictions on us and may limit our ability to engage in activities that may be in our long-term best interest. Among other things, those covenants impose restrictions on our ability to:

- incur additional indebtedness;
- pay dividends or make other distributions or repurchase or redeem capital stock;
- prepay, redeem or repurchase certain debt;
- make loans and investments;
- consolidate, merge or sell all or substantially all of our assets;
- incur liens;
- grant additional security interests and provide new guarantees;
- enter into transactions with affiliates;
- enter into sale-leaseback transactions;
- invest in joint ventures and make capital expenditures; and
- alter the businesses we conduct.

As a result of these restrictions, we may be: (i) limited in how we conduct our business; (ii) unable to raise additional debt or equity financing when necessary or desirable; or (iii) unable to compete effectively or take advantage of new business opportunities. These restrictions could materially affect our ability to grow our business in accordance with our strategic operational and growth initiatives, which would harm our business.

***If credit markets become unstable and we are not able to access them to obtain financing on commercially reasonable terms when needed or desirable, our business could be materially harmed and our results of operations could be adversely affected.***

Our ability to secure additional capital resources to fund our operational and growth strategies may depend on our ability to access the credit markets. During the past few years, credit markets have experienced unstable conditions and, for a period of time, they were essentially unavailable due to a severe banking crisis. We cannot predict whether we will be able to access the credit markets when necessary or desirable. If we are not able to access credit markets and obtain financing on commercially reasonable terms when needed, our business could be materially harmed and our results of operations could be adversely affected.

***We are presently the subject of legal proceedings that, if resolved unfavorably, could have an adverse effect on us.***

We are a party to various ongoing government investigations, legal proceedings and other related matters, which are described under "Legal Proceedings" in Item 3 and Note 13 to the Consolidated Financial Statements in Item 8 of Part II. Those proceedings include, among other things, government investigations. Should an unfavorable outcome occur in some or all of our current legal proceedings, or if successful claims and other actions are brought against us in the future, there could be a materially adverse effect on our financial position, results of operations and liquidity.

As described above in further detail, government investigations, as well as qui tam lawsuits, may lead to material fines, penalties, damages payments or other sanctions, including exclusion from government health care programs. Settlements of lawsuits involving Medicare and Medicaid issues routinely require both monetary payments and corporate integrity agreements, each of which could have a materially adverse effect on our business, financial condition, results of operations and/or cash flows.

***We may incur liabilities not covered by our insurance or which exceed our insurance limits, or a party to our insurance program could become insolvent or otherwise not meet its contractual obligations.***

In the ordinary course of business, our subsidiary hospitals and other health care facilities and our employed physicians are subject to medical malpractice lawsuits, product liability lawsuits and other legal actions. Some of these actions may involve large claims, as well as significant defense costs. We self-insure a substantial portion of our professional liability risks. Based on our past experience and current actuarial estimates, we believe that our insurance coverage and our self-insurance reserves are sufficient to cover claims arising from the operations of our subsidiary hospitals and other health care facilities and our physician practices. However, if payments for indemnity claims and related expenses exceed our estimates or if payments are required to be made by us that are not covered by insurance, our business could be harmed and our results of operations could be adversely impacted. Also, one or more of the unrelated insurance and reinsurance companies that provide us coverage could become insolvent or otherwise be unable to fulfill their contractual obligations to us, each of which could adversely affect our business and results of operations.

***Our facilities are heavily concentrated in Florida, Mississippi and Tennessee, which makes us sensitive to regulatory, economic and competitive changes in those states, as well as the harmful effects of hurricanes and other severe weather activity in regions in and around the Gulf of Mexico.***

As of December 31, 2011, we operated 66 hospitals, including 42 in Florida, Mississippi and Tennessee. Our home office is also located in Florida. Such geographic concentration makes us particularly sensitive to regulatory, economic, environmental and competitive conditions in those states. Any material changes in those factors in Florida, Mississippi or Tennessee could have a disproportionate effect on our business and results of operations.

Moreover, regions in and around the Gulf of Mexico commonly experience hurricanes and other extreme weather conditions. As a result, certain of our health care facilities, especially those in Florida and Mississippi, and our home office are susceptible to physical damage and business interruption from an active hurricane season or a single severe storm. Moreover, global climate change could increase the intensity of individual hurricanes or the number of hurricanes that occur each year. Even if our facilities are not directly damaged, we may experience considerable disruptions in our operations due to property damage experienced in storm-affected areas by our patients, physicians, payors, vendors and others. Additionally, long-term adverse weather conditions, whether caused by global climate change or otherwise, could cause an outmigration of people from the communities where our hospitals are located. If any of the circumstances described above occurred, there could be a harmful effect on our business and our results of operations could be adversely affected.

***The failure of certain employers or the closure of certain facilities could have a disproportionate impact on our hospitals and harm our business.***

The economies in the non-urban communities where our hospitals operate are often dependant on a small number of large employers. Those employers often provide income and health insurance for a disproportionately large number of community residents who may depend on our hospitals and other health care facilities for their care. The failure of one or more large employer or the closure or substantial reduction in the number of individuals employed at facilities located in or near the communities where our hospitals operate, could cause affected employees to move elsewhere to seek employment or lose insurance coverage that was otherwise available to them. The occurrence of these events could adversely affect our revenue and results of operations, thereby harming our business.

***Our growth strategy depends, in part, on acquisitions. However, we may not be able to continue to acquire hospitals and other ancillary health care businesses that meet our target criteria. We may also have difficulty acquiring hospitals from not-for-profit entities due to regulatory scrutiny and other restrictions.***

Acquisitions of general acute care hospitals and other ancillary health care businesses in non-urban markets are part of our overall growth strategy. We face competition for potential acquisition targets primarily from other for-profit health care companies. Some of our competitors have greater resources than we do. Additionally, many states have enacted, or from time to time consider enacting, laws that affect the conversion or sale of not-for-profit hospitals to for-profit entities. These laws generally require prior approval from state attorneys general, advance notification and community involvement. Moreover, attorneys general in states without specific conversion

legislation may exercise broad discretionary authority over such transactions. Although the level of government involvement varies from state to state, the trend is to provide increased regulatory review and, in some cases, approval of a transaction where a not-for-profit entity sells a health care facility to a for-profit entity. The adoption of new or expanded conversion legislation, increased review of not-for-profit hospital conversions or our inability to effectively compete against other potential buyers could make it more difficult for us to acquire hospitals and other ancillary health care businesses, increase our acquisition costs and/or make it difficult for us to complete acquisitions that otherwise meet our target criteria, any of which could adversely affect our growth strategy and results of operations.

***The Health Care Reform Act restricts our ability to enter into new joint ventures with physicians and subjects our existing joint ventures to substantial limitations. Because these joint ventures were an important part of our growth strategy prior to the enactment of the Health Care Reform Act, the new restrictions may have an adverse effect on our business.***

At a number of our hospitals, we have partnered with local physicians in the ownership of the facility. Such arrangements were entered into under a provision of the Stark law that allowed physicians to invest in an entire hospital, such provision is commonly referred to as the "whole hospital" exception. The Health Care Reform Act changed the whole hospital exception such that existing physician investments in a whole hospital are only permitted to continue under a grandfather clause if the arrangement satisfies certain requirements. However, physicians are now prohibited from increasing their aggregate ownership percentage in any grandfathered joint venture hospital and/or entering into new hospital joint ventures. Additionally, the Health Care Reform Act restricts the ability of existing physician-owned hospitals to expand the number of operating rooms, procedure rooms and licensed beds that they operate. Prior to the passage of the Health Care Reform Act, joint ventures with physician partners had been an important component of our growth strategy. Our inability to enter into future hospital joint ventures with physicians may slow our strategic growth plans. Moreover, we may be unable to expand the services at our affected hospitals and/or effectively compete in certain markets if the Health Care Reform Act or other laws and regulations materially restrict our grandfathered joint venture hospitals from increasing their operating rooms, procedure rooms and licensed beds, each of which could adversely affect our results of operations and harm our business.

***We may fail to improve or integrate the operations of the hospitals we acquire, which could harm our results of operations.***

Prior to their acquisition, most of the hospitals we acquire were experiencing operating losses or had significantly lower operating margins than the hospitals we operate. We may be unable to timely and effectively integrate the hospitals that we acquire with our ongoing operations or we may experience delays implementing operating procedures and systems at those hospitals. Integrating a new hospital can be expensive and time consuming and could disrupt our ongoing business, negatively affect our cash flow and distract management and other key personnel. Acquired hospitals require transitions from, and the integration of, operations, personnel and information systems. If we are unable to improve the operating margins of the hospitals we acquire, operate such hospitals profitably or effectively and timely integrate their operations, our results of operations could be harmed.

***The availability of approved Medicare and Medicaid provider numbers may be delayed following our acquisition of a hospital.***

Following an acquisition, we generally seek approval to use the predecessor hospital's provider numbers for Medicare and Medicaid reimbursement. If we are unable to obtain the necessary approvals to use such provider numbers on a timely basis, our receipt of Medicare and Medicaid reimbursement could be delayed. Such delays could temporarily harm our cash flows.

***If we acquire hospitals or other ancillary health care businesses with unknown or contingent liabilities, we could become liable for material obligations.***

Hospitals and other ancillary health care businesses that we acquire may have unknown or contingent liabilities, including, but not limited to, liabilities for failure to comply with health care laws and regulations, medical and general professional liabilities, workers' compensation liabilities, tax liabilities and liabilities for unacceptable business practices. Although we typically exclude significant liabilities from our acquisition transactions and seek indemnification from the sellers for these matters, we could experience difficulty enforcing those obligations or we could incur material liabilities for the pre-acquisition activities of the hospitals and other ancillary health care facilities that we acquire. Such liabilities and related legal or other costs could harm our business and results of operations.

***Other hospitals and freestanding outpatient facilities provide services similar to ours, which may raise the level of competition we face and adversely affect our results of operations.***

The health care industry is highly competitive and competition among hospitals and other health care providers has intensified in recent years. In some of the geographic areas where we operate, there are other hospitals that provide services comparable to those offered by our hospitals and other health care facilities. Some of those competitor hospitals are owned by government agencies and supported by tax revenue and others are owned by not-for-profit corporations and may be supported, in part, by endowments and charitable contributions. Such support is not available to our hospitals. In some cases, our competitors may be a significant distance away from our facilities; however, patients in our markets may migrate, may be referred by local physicians or may be required by their health plan to travel to these hospitals for care. Furthermore, some of our competitors may be better equipped than us and can offer a broader range of services than we do. Additionally, outpatient treatment and diagnostic imaging facilities, outpatient surgical centers, specialized care providers (e.g., oncology, physical therapy, etc.) and freestanding ambulatory surgical centers (each of which may have physician ownership interests) have increased in number and accessibility in recent years. This broader selection of health care facilities in the communities that we serve has challenged our market share. If our hospitals and other health care facilities are not able to effectively attract patients, our business and results of operations could be harmed.

***If we are not able to provide high quality medical care at a reasonable price, patients may choose to receive their health care from our competitors.***

In recent years, the number of quality measures that hospitals are required to report publicly has increased. CMS publishes performance data related to quality measures and data on patient satisfaction surveys that hospitals submit in connection with the Medicare program. Federal law provides for the future expansion of the number of quality measures that must be reported. Additionally, the Health Care Reform Act requires all hospitals to annually establish, update and make public a list of their standard charges for products and services. If any of our hospitals achieve poor results on their quality measures or patient satisfaction surveys (or results that are lower than our competitors) or if our standard charges are higher than our competitors, our patient volume could decline because patients may elect to use competing hospitals or other health care providers that have better metrics and pricing. This circumstance could harm our business and results of operations.

***Our performance depends on our ability to recruit and retain quality physicians.***

Physicians make admitting and other decisions regarding the appropriate course of patient treatment, which, in turn, affect hospital revenue. Therefore, the success of our hospitals depends, in part, on the number and quality of the physicians on their medical staffs, the admitting practices of those physicians and continued good relations with such physicians. Many of the physicians working at our hospitals are not our employees and, in a number of the markets that we serve, they have admitting privileges at hospitals other than our own. If we are unable to provide adequate support personnel or technologically advanced equipment and facilities that meet physicians' needs, they may be discouraged from referring patients to our facilities and our results of operations could be adversely affected.

Additionally, we could find it difficult to attract an adequate number of physicians to practice in certain of the non-urban communities where our hospitals are located. An inability to recruit physicians to those communities or the loss of physicians in those communities could make it difficult to attract patients to our hospitals and thereby harm our business and results of operations. On a national level, a shortage of physicians is a possible unintended consequence of the Health Care Reform Act. The millions of uninsured individuals who will obtain insurance under the new law will eventually be in need of primary care and other physicians, whose numbers may not increase proportionately. In the future, this shortage may require us to enhance wages and benefits to recruit and retain qualified physicians or require us to hire expensive temporary and per diem personnel.

***If we do not continually enhance our hospitals with the most recent technological advances in diagnostic and surgical equipment, our ability to maintain and expand our markets will be adversely affected.***

The technology used in medical equipment and related devices is constantly evolving and, as a result, manufacturers and distributors continue to offer new and upgraded products to health care providers. To compete effectively, we must continually assess our equipment needs and upgrade when significant technological advances occur. If our hospitals do not stay current with technological advances in the health care industry, patients may seek treatment from other providers and/or physicians may refer their patients to alternate sources, which could adversely affect our results of operations and harm our business.

***Our hospitals face competition for medical support staff, including nurses, pharmacists, medical technicians and other personnel, which may increase our labor costs and adversely affect our business.***

We are highly dependent on our experienced medical support personnel, including nurses, pharmacists and lab technicians, seasoned local hospital management and other medical personnel. We compete with other health care providers to recruit and retain these health care professionals. On a national level, a shortage of nurses and certain other medical support personnel has been a significant operating issue for a number of health care providers. In the future, this shortage may require us to enhance wages and benefits to recruit and retain such personnel or require us to hire expensive temporary and per diem personnel. Additionally, to the extent that a significant portion of our employee base unionizes, or attempts to unionize, our labor costs could increase. Certain proposed changes in federal labor laws, such as the Employee Free Choice Act of 2009, could increase the likelihood of unionization at our facilities. If our wages and related expenses rise, we may not be able to correspondingly increase our reimbursement rates. Our inability to recruit and retain qualified hospital management, nurses and other medical support personnel or our inability to modulate labor costs could adversely affect our results of operations and harm our business.

***We depend heavily on key management personnel and the loss of the services of one or more of our key executives or a significant portion of our local hospital management personnel could harm our business.***

Our success depends, in large part, on the skills, experience and efforts of our senior management team and the efforts, ability and experience of key members of our local hospital management teams. We do not maintain employment agreements with our management personnel. The loss of the services of one or more members of our senior management team or a significant portion of our local hospital management teams could significantly weaken our ability to efficiently deliver health care services, which could harm our business.

***Our business could be harmed by a failure of our proprietary information technology system.***

The performance of our proprietary management information system, known as the Pulse System®, is critical to our business operations. Any failure that causes a material interruption in the availability of the Pulse System® could adversely affect our operations or delay our cash collections. Although we have implemented antivirus, network security and disaster recovery measures, our servers could become vulnerable to computer viruses, break-ins, disruptions from unauthorized tampering, hurricane-related failures and other extreme weather conditions. Any of these circumstances could result in interruptions, delays, the loss or corruption of data, or a general lack of availability of the Pulse System®, each of which could harm our business and results of operations. Moreover, in the event of a failure of the Pulse System®, we may be required to devote substantial personnel, financial and technological resources to correct any then existing deficiencies and/or enhance the system design to prevent such a failure from occurring again in the future, which could also harm our business and results of operations.

***If we fail to effectively and timely implement electronic health record systems, our operations could be harmed.***

As required by the portion of the Economic Stimulus Act commonly referred to as "HITECH," CMS has developed and is implementing an incentive payment program for eligible hospitals and health care professionals that adopt and meaningfully use certified electronic health record technology. HHS is using the Provider Enrollment, Chain and Ownership System, or PECOS, to verify Medicare enrollment prior to making electronic health record incentive program payments. If our hospitals or physicians are unable to meet the requirements for participation in the incentive payment program, including having an enrollment record in PECOS, we will not be eligible to receive incentive payments that could offset some of the costs of implementing an electronic health record system. Further, beginning in federal fiscal year 2015, eligible hospitals and professionals that fail to demonstrate meaningful use of certified electronic health record technology will be subject to reduced payments from Medicare. Any failure by us to effectively implement an electronic health record system in a timely manner, or maintain currently compliant systems, could have an adverse effect on our results of operations.

HITECH provides that patients have the right to receive information regarding their treatment and the payments made for their health care services during the three years prior to their request. HHS released a proposed rule on May 31, 2011 that would require hospitals and health care professionals to keep records about not only disclosures of, but also internal access to, certain patient health records. If implemented, such proposed rule would mean, among other things, that patients would have a right to request the names of every person who viewed their records. If implemented in its current form, the proposed rule could require us to devote significant resources to further enhance our recordkeeping systems.

#### **Item 1B. Unresolved Staff Comments.**

Not applicable.

## Item 2. Properties.

The table below presents certain information with respect to our hospitals as of December 31, 2011. For more information regarding the utilization of our facilities, see "Business - Selected Operating Statistics" in Item 1.

Hospital	City	Licensed Beds	Operational Status	Date Acquired
<b>Alabama</b>				
Riverview Regional Medical Center (1)	Gadsden	281	Owned	July 1991
Stringfellow Memorial Hospital (1)	Anniston	125	Leased	January 1997
<b>Arkansas</b>				
Summit Medical Center (1)	Van Buren	103	Leased	May 1987
Sparks Health System	Fort Smith	492	Owned	December 2009
<b>Florida</b>				
Highlands Regional Medical Center	Sebring	126	Leased	August 1985
Heart of Florida Regional Medical Center (1)	Greater Haines City	194	Owned	August 1993
Sebastian River Medical Center	Sebastian	154	Owned	September 1993
Charlotte Regional Medical Center	Punta Gorda	208	Owned	December 1994
Brooksville Regional Hospital (1)	Brooksville	120	Leased	June 1998
Spring Hill Regional Hospital (1)	Spring Hill	124	Leased	June 1998
Lower Keys Medical Center	Key West	167	Leased	May 1999
Pasco Regional Medical Center (1)	Dade City	120	Owned	September 2000
Lehigh Regional Medical Center	Lehigh Acres	88	Owned	December 2001
Santa Rosa Medical Center	Milton	129	Leased	January 2002
Seven Rivers Regional Medical Center	Crystal River	128	Owned	November 2003
Peace River Regional Medical Center	Port Charlotte	219	Owned	February 2005
Venice Regional Medical Center	Venice	312	Owned	February 2005
Bartow Regional Medical Center	Bartow	72	Owned	April 2005
St. Cloud Regional Medical Center (1)	St. Cloud	84	Owned	February 2006
Physicians Regional Medical Center-Pine Ridge	Naples	101	Owned	May 2006
Physicians Regional Medical Center-Collier Boulevard	Naples	100	Owned	Not applicable (2)
Shands Lake Shore Regional Medical Center (1)	Lake City	99	Leased	July 2010
Shands Live Oak Regional Medical Center (1)	Live Oak	15	Owned	July 2010
Shands Starke Regional Medical Center (1)	Starke	25	Owned	July 2010
Wuesthoff Medical Center - Rockledge	Rockledge	298	Owned	October 2010
Wuesthoff Medical Center - Melbourne	Melbourne	115	Owned	October 2010
<b>Georgia</b>				
East Georgia Regional Medical Center (1)	Statesboro	150	Owned	October 1995
Walton Regional Medical Center (3)	Monroe	77	Owned	September 2003
Barrow Regional Medical Center	Winder	56	Owned	January 2006
<b>Kentucky</b>				
Paul B. Hall Regional Medical Center (1)	Paintsville	72	Owned	January 1979
<b>Mississippi</b>				
Biloxi Regional Medical Center	Biloxi	198	Leased	September 1986
Natchez Community Hospital (1)	Natchez	101	Owned	September 1993
Northwest Mississippi Regional Medical Center	Clarksdale	195	Leased	January 1996
Crossgates River Oaks Hospital	Brandon	149	Leased	January 1997
River Oaks Hospital	Flowood	160	Owned	January 1998
Woman's Hospital at River Oaks	Flowood	109	Owned	January 1998
Central Mississippi Medical Center	Jackson	429	Leased	April 1999
Madison River Oaks Medical Center (4)	Canton	67	Owned	January 2003
Gilmore Memorial Regional Medical Center	Amory	95	Owned	December 2005
Gulf Coast Medical Center (5)	Biloxi	144	Inactive	Not applicable
Tri-Lakes Medical Center (1)	Batesville	112	Owned	May 2011
<b>Missouri</b>				
Twin Rivers Regional Medical Center	Kennett	116	Owned	November 2003
Poplar Bluff Regional Medical Center (1) (6)	Poplar Bluff	423	Owned	November 2003

Hospital	City	Licensed Beds	Operational Status	Date Acquired
<b>North Carolina</b>				
Lake Norman Regional Medical Center (1)	Mooresville	123	Owned	January 1986
Sandhills Regional Medical Center	Hamlet	64	Owned	August 1987
Davis Regional Medical Center	Statesville	143	Owned	October 2000
<b>Oklahoma</b>				
Medical Center of Southeastern Oklahoma (1)	Durant	148	Owned	May 1987
Midwest Regional Medical Center (1)	Midwest City	255	Leased	June 1996
<b>Pennsylvania</b>				
Heart of Lancaster Regional Medical Center (1)	Lititz	148	Owned	July 1999
Lancaster Regional Medical Center (1)	Lancaster	214	Owned	July 2000
Carlisle Regional Medical Center (1)	Carlisle	165	Owned	June 2001
<b>South Carolina</b>				
Carolina Pines Regional Medical Center (1)	Hartsville	116	Owned	September 1995
Chester Regional Medical Center	Chester	82	Leased	October 2004
<b>Tennessee</b>				
Jamestown Regional Medical Center	Jamestown	85	Owned	January 2002
University Medical Center (1)	Lebanon	245	Owned	November 2003
Harton Regional Medical Center (1)	Tulahoma	135	Owned	November 2003
Physicians Regional Medical Center (7)	Knoxville	419	Owned	September 2011
Turkey Creek Medical Center	Knoxville	101	Owned	September 2011
Jefferson Memorial Hospital	Jefferson City	58	Leased	September 2011
Newport Medical Center (7)	Newport	130	Owned	September 2011
LaFollette Medical Center	LaFollette	66	Leased	September 2011
North Knoxville Medical Center	Powell	108	Owned	September 2011
St. Mary's Medical Center of Scott County (8)	Oneida	25	Leased	September 2011
Riverside hospital campus	Knoxville	293	Owned/Inactive	September 2011
<b>Texas</b>				
Dallas Regional Medical Center at Galloway	Mesquite	202	Owned	January 2002
<b>Washington</b>				
Yakima Regional Medical and Cardiac Center (1)	Yakima	214	Owned	August 2003
Toppenish Community Hospital (1)	Toppenish	63	Owned	August 2003
<b>West Virginia</b>				
Williamson Memorial Hospital (1)	Williamson	76	Owned	June 1979
Total licensed beds at December 31, 2011		<u>10,330</u>		

- (1) As of December 31, 2011, this hospital is partially owned by local physicians and/or other health care entities; however, we continue to own the majority equity interest in such hospital and manage its day-to-day operations. Subsequent to December 31, 2011, we repurchased all of the minority equity interests in respect of Poplar Bluff Regional Medical Center.
- (2) De novo hospital that we opened on February 5, 2007.
- (3) We are contractually obligated to build a replacement hospital at this location no later than December 31, 2012. Construction is underway and the new hospital is expected to open during the quarter ending June 30, 2012.
- (4) Madison River Oaks Medical Center is a newly constructed hospital that we opened in May 2011 to replace our predecessor hospital in Canton, Mississippi.
- (5) We have applied to the Mississippi State Department of Health for a certificate of need that would allow us to transfer these licensed beds to a hospital that we would build in the Biloxi, Mississippi marketplace.
- (6) Poplar Bluff Regional Medical Center consists of a north campus (a 213-bed building that we lease) and a south campus (a 210-bed building that we own). We are currently building a new general acute care hospital in Poplar Bluff, Missouri that will ultimately replace our south campus facility. We expect that the new 250-bed hospital will open during the quarter ending March 31, 2013.
- (7) The number of licensed beds includes ancillary facilities.
- (8) The lease agreement at this hospital expires in May 2012 and will not be renewed or otherwise modified.

As indicated in the above table, we currently lease certain facilities pursuant to long-term leases that provide us with the exclusive right to use and control each hospital's operations. The facilities we lease and the corresponding year of lease expiration are as follows: Highlands Regional Medical Center (2025), Biloxi Regional Medical Center (2040), Summit Medical Center (2028), Northwest Mississippi Regional Medical Center (2035), Midwest Regional Medical Center (2035), Crossgates River Oaks Hospital (2026), Brooksville Regional Hospital/Spring Hill Regional Hospital (2043), Central Mississippi Medical Center (2040), Lower Keys Medical Center (2029), Chester Regional Medical Center (2034), Santa Rosa Medical Center (2045), Stringfellow Memorial Hospital (2048), Shands Lake Shore Regional Medical Center (2040), Jefferson Memorial Hospital (2021), LaFollette Medical Center (2015) and the north campus at Poplar Bluff Regional Medical Center (2014).

Our home office is in an office building complex in Naples, Florida that we own. We use approximately 36% of the complex and lease the remaining space. We have engaged an outside property management company to manage the office complex on our behalf.

As discussed at Note 10 to the Consolidated Financial Statements in Item 8 of Part II, we (i) closed the Woman's Center at Dallas Regional Medical Center in Mesquite, Texas on June 1, 2008 and (ii) acquired the Riverside hospital campus, which is a shuttered facility in Knoxville, Tennessee, as part of a transaction with Mercy Health Partners, Inc. that we completed on September 30, 2011. We are currently evaluating various disposal alternatives for these idle facilities; however, the timing of such divestitures has not yet been determined. Additionally, we lease a building in Canton, Mississippi where our hospital was previously located and we are currently considering several alternatives for this lease arrangement that expires in 2042.

As discussed at Note 2 to the Consolidated Financial Statements in Item 8 of Part II, our senior secured credit facilities with a syndicate of banks, 6.125% Senior Notes due 2016 and a \$10.0 million secured demand promissory note with a bank are all secured by a significant portion of our real property.

We believe that our facilities are suitable and adequate for our needs.

### **Item 3. Legal Proceedings.**

We operate in a highly regulated and litigious industry. As a result, we have been, and expect to continue to be, subject to various claims, lawsuits, government investigations and regulatory proceedings. The ultimate resolution of these matters, individually or in the aggregate, could have a materially adverse effect on our business, financial condition, results of operations and/or cash flows. We are currently a party to a number of legal and regulatory proceedings, including those described below.

**Ascension Health Lawsuit.** On February 14, 2006, Health Management Associates, Inc. (referred to as "Health Management" for the remainder of this Item 3) announced the termination of non-binding negotiations with Ascension Health ("Ascension") and the withdrawal of a non-binding offer to acquire Ascension's St. Joseph Hospital, a general acute care hospital in Augusta, Georgia. On June 8, 2007, certain Ascension subsidiaries filed a lawsuit against Health Management, entitled *St. Joseph Hospital, Augusta, Georgia, Inc. et al. v. Health Management Associates, Inc.*, in Georgia Superior/State Court of Richmond County claiming that Health Management (i) breached an agreement to purchase St. Joseph Hospital and (ii) violated a confidentiality agreement. The plaintiffs claim at least \$40 million in damages. Health Management removed the case to the U.S. District Court for the Southern District of Georgia, Augusta Division (No. 1:07-CV-00104). On July 13, 2010, the plaintiffs filed a motion for partial summary judgment and Health Management filed a motion for summary judgment. On March 30, 2011, Health Management's motion for summary judgment was granted as to all of plaintiffs' claims, except for the breach of confidentiality claim, and plaintiffs' motion for partial summary judgment was denied. On June 15, 2011, the case was stayed pending resolution of the appellate process. On July 8, 2011, the plaintiffs filed a notice of appeal to the United States Court of Appeals for the Eleventh Circuit (Case Number: 11-13069). Oral argument is scheduled for the week of April 30, 2012.

We do not believe there was a binding acquisition contract with Ascension or any of its subsidiaries and we do not believe Health Management breached a confidentiality agreement. Accordingly, we will continue to vigorously defend Health Management against the allegations, including the pending appeal. We do not believe that the final outcome of this matter will be material.

**Medicare/Medicaid Billing Lawsuits.** On January 11, 2010, Health Management and one of its subsidiaries were named in a qui tam lawsuit entitled *United States of America ex rel. J. Michael Mastey v. Health Management Associates, Inc. et al.* in the U.S. District Court for the Middle District of Florida, Tampa Division. The plaintiff's complaint alleged that, among other things, the defendants erroneously submitted claims to Medicare and that those claims were falsely certified to be in compliance with Section 1877 of the Social Security Act of 1935 (commonly known as the "Stark law") and the Anti-Kickback Statute. The plaintiff's complaint further alleged that the defendants' conduct violated the federal False Claims Act of 1863 (the "False Claims Act"). The plaintiff seeks recovery of all Medicare and Medicaid reimbursement that the defendants received as a result of the alleged false

certifications and treble damages under the False Claims Act, as well as a civil penalty for each Medicare and Medicaid claim supported by such alleged false certifications. On August 18, 2010, the plaintiff filed a first amended complaint that was similar to the original complaint. On September 27, 2010, the defendants moved to dismiss the first amended complaint for failure to state a claim with the particularity required by Rule 9(b) of the Federal Rules of Civil Procedure and failure to state a claim upon which relief can be granted pursuant to Rule 12(b)(6) of those federal rules. On November 11, 2010, the plaintiff filed a memorandum of law in opposition to the defendants' motion to dismiss. On February 23, 2011, the case was transferred to the U.S. District Court for the Middle District of Florida, Fort Myers Division (No. 2:11-cv-00089-JES-DNF). On May 5, 2011, the plaintiff filed a second amended complaint, which was similar to the first amended complaint. On May 17, 2011, the defendants moved to dismiss the second amended complaint on the same bases set forth in their earlier motion to dismiss. On February 16, 2012, the court granted the defendants' motion to dismiss, without prejudice. The court's order permits the plaintiff to file an amended complaint within 21 days. If the plaintiff amends the complaint, we will vigorously defend Health Management and its subsidiary against the allegations. We do not believe that the final outcome of this matter will be material.

On December 13, 2011, the U.S. District Court for the Middle District of Tennessee ordered that a *qui tam* lawsuit entitled *United States ex rel. Kevin Dennis, et al. v. Health Management Associates, Inc. et al.* (Case No. 3:09-cv-00484) be partially unsealed and served on the defendants and that certain other contents of the court's file remain under seal. To date, we have not been served with the complaint. The complaint was filed under seal on or about May 27, 2009 and alleges that, among other things, the defendants erroneously submitted claims to Medicare and other health care programs funded by the federal government and the State of Tennessee and that those claims were falsely certified to be in compliance with the Stark law, the Anti-Kickback Statute and the analogous laws of the State of Tennessee. The plaintiffs' complaint further alleges that the defendants' conduct violated the False Claims Act and the Tennessee Medicaid False Claims Act. The plaintiff seeks recovery in the amount of triple the amount of the actual damages that the United States and the State of Tennessee have sustained as a result of the defendants' alleged fraudulent and illegal recruitment and billing practices, a civil penalty for each alleged false claim that the defendants presented or caused to be presented to the United States or the State of Tennessee, and a civil penalty for each of the defendants' acts that allegedly violated the Tennessee Medicaid False Claims Act, as well as unspecified compensatory and punitive damages. On December 7, 2011, the State of Tennessee notified the court of its decision not to intervene in the action and, on December 8, 2011, the United States notified the court that it was also declining to intervene. We intend to vigorously defend Health Management and its subsidiary against the allegations in this matter. We do not believe that the final outcome of this matter will be material.

**Governmental Matters.** Several Health Management hospitals received letters during the second half of 2009 requesting information in connection with a U.S. Department of Justice ("DOJ") investigation relating to kyphoplasty procedures. Kyphoplasty is a minimally invasive spinal procedure used to treat vertebral compression fractures. The DOJ is currently investigating hospitals and hospital operators in multiple states to determine whether certain Medicare claims for kyphoplasty were incorrect when billed as an inpatient service rather than as an outpatient service. We believe that the DOJ's investigation originated with a False Claims Act lawsuit against Kyphon, Inc., the company that developed the kyphoplasty procedure. The requested information has been provided to the DOJ and we are cooperating with the investigation. To date, the DOJ has not asserted any monetary or other claims against the Health Management hospitals in this matter. Based on the aggregate billings for inpatient kyphoplasty procedures during the period under review that were performed at the Health Management hospitals subject to the DOJ's inquiry, we do not believe that the final outcome of this matter will be material.

During September 2010, Health Management received a letter from the DOJ indicating that an investigation was being conducted to determine whether certain Health Management hospitals improperly submitted claims for the implantation of implantable cardioverter defibrillators ("ICDs"). The DOJ's investigation covers the period commencing with Medicare's expansion of coverage for ICDs in 2003 to the present. The letter from the DOJ further indicates that the claims submitted by Health Management's hospitals for ICDs and related services need to be reviewed to determine if Medicare coverage and payment was appropriate. During 2010, the DOJ sent similar letters and other requests to a large number of unrelated hospitals and hospital operators across the country as part of a nation-wide review of ICD billing under the Medicare program. We have, and will continue to, cooperate with the DOJ in its ongoing investigation, which could potentially give rise to claims against Health Management and/or certain of its subsidiary hospitals under the False Claims Act or other statutes, regulations or laws. Additionally, we recently commenced an internal review of hospital medical records related to ICDs that are the subject of the DOJ investigation. To date, the DOJ has not asserted any monetary or other claims against Health Management or its hospitals in this matter and, at this time, we are unable to determine the potential impact, if any, that will result from the final resolution of the investigation.

The U.S. Department of Health and Human Services, Office of Inspector General ("HHS-OIG") and the DOJ, including the Civil Division and U.S. Attorney's Offices in the Eastern District of Pennsylvania, the Middle District of Florida, the Eastern District of Oklahoma, the Middle District of Tennessee, the Western District of North

Carolina, the District of South Carolina and the Middle District of Georgia, are currently investigating Health Management and certain of its subsidiaries (HHS-OIG and the DOJ are collectively referred to as "Government Representatives"). We believe that such investigations relate to the Anti-Kickback Statute, the Stark law and the False Claims Act and are focused on: (i) physician referrals, including financial arrangements with our whole-hospital physician joint ventures; (ii) the medical necessity of emergency room tests and patient admissions, including whether Pro-Med software has led to any medically unnecessary tests or admissions; and (iii) the medical necessity of certain surgical procedures. We further believe that the investigations may have originated as a result of qui tam lawsuits filed on behalf of the United States. In connection with the investigations, HHS-OIG served subpoenas on Health Management on May 16, 2011 and July 21, 2011 requesting records. Additionally, Government Representatives have interviewed both our current and former employees. We are conducting internal investigations and have met with Government Representatives on numerous occasions to respond to their inquiries. We believe that the HHS-OIG subpoenas, which apply system-wide, may have been served pursuant to the authority of HHS-OIG to investigate health care fraud.

On February 22, 2012 and February 24, 2012, HHS-OIG served subpoenas on certain Health Management hospitals relating to those hospitals' relationships with Allegiance Health Management, Inc. ("Allegiance"). Allegiance, which is unrelated to Health Management, is a post acute health care management company that provides intensive outpatient psychiatric ("IOP") services to patients. The Health Management hospitals that were served subpoenas were: (i) Central Mississippi Medical Center in Jackson, Mississippi; (ii) Crossgates River Oaks Hospital in Brandon, Mississippi; (iii) Davis Regional Medical Center in Statesville, North Carolina; (iv) Lake Norman Regional Medical Center in Mooresville, North Carolina; (v) the Medical Center of Southeastern Oklahoma in Durant, Oklahoma; and (vi) Natchez Community Hospital in Natchez, Mississippi. Each of those hospitals has or had a contract with Allegiance. Among other things, the subpoenas seek: (i) documents related to the hospitals' financial relationships with Allegiance; (ii) documents related to patients who received IOP services from Allegiance at the Health Management hospitals, including their patient medical records; (iii) documents relating to complaints or concerns regarding Allegiance's IOP services at the Health Management hospitals; (iv) documents relating to employees, physicians and therapists who were involved in the provision of IOP services provided by Allegiance at the Health Management hospitals; and (v) other documents related to Allegiance including leases, contracts, policies and procedures, training documents, budgets and financial analyses. The period of time covered by the subpoenas is January 1, 2008 through the date of subpoena compliance. We believe that HHS-OIG has served similar subpoenas on other non-Health Management hospitals that had contracts with Allegiance. We intend to comply with the investigations. At this time, we are unable to determine the potential impact, if any, that will result from the final resolution of these investigations.

In addition to the abovementioned subpoenas and investigations, certain of our hospitals have received other requests for information from state and federal agencies. We are cooperating with all of the ongoing investigations by collecting and producing the requested materials. Because a large portion of our government investigations are in their early stages, we are unable to evaluate the outcome of such matters or determine the potential impact, if any, that could result from their final resolution.

**Class Action Lawsuits.** On or about January 25, 2012, Health Management, certain of its executive officers and one of its directors were named as defendants in an action entitled *Miklen Sapssov v. Health Management Associates, Inc. et al.*, which was filed in the U. S. District Court for the Middle District of Florida (No. 2:12-CV-00046). This action purports to be brought on behalf of stockholders who purchased our common stock during the period July 27, 2009 through January 9, 2012. The plaintiff alleges, among other things, that Health Management and the other defendants violated Section 10(b) of the Securities Exchange Act of 1934 by making allegedly false and misleading statements in certain public disclosures regarding our business and financial results. The plaintiff alleges that our financial performance was based, in part, on improper billing practices. The plaintiff seeks unspecified damages. A substantially similar purported class action lawsuit, entitled *Norfolk County Retirement System v. Health Management Associates, Inc., et al.*, was filed against the same defendants on or about February 2, 2012 in the U. S. District Court for the Middle District of Florida (No. 8:12-CV-00228). We intend to vigorously defend Health Management against the allegations in these matters. Because the abovementioned lawsuits are in their early stages, we are unable to evaluate their outcome or determine the potential impact, if any, that could result from their final resolution.

**Wrongful Termination Lawsuit.** On or about October 19, 2011, a wrongful termination action was commenced against us by Paul Meyer, our former Director of Compliance. That litigation, entitled *Meyer v. Health Management Associates, Inc.*, was commenced in the Circuit Court of the Seventeenth Judicial Circuit in and for Broward County, Florida (Case No. 11-25334(09)). The plaintiff seeks unspecified compensatory and punitive damages. On November 18, 2011, we removed the case to the United States District Court, Southern District of Florida, Fort Lauderdale Division (Case No. 0:11-cv-62479-RNS). On January 20, 2012, the case was remanded to the Circuit Court of the Seventeenth Judicial Circuit in and for Broward County, Florida. Mr. Meyer was terminated after insubordinately refusing to cooperate with our efforts to comply with our obligations under a

government subpoena by refusing to return documents belonging to us that were in his possession. Moreover, Mr. Meyer's failure to cooperate with us in response to a subpoena was contrary to both the intent and purpose of our compliance department and our company-wide compliance program. We have filed a counterclaim against Mr. Meyer for breach of contract, conversion and breach of duty of loyalty. We intend to vigorously defend against the wrongful termination allegations made by Mr. Meyer and we do not believe that the final outcome of this matter will be material.

**Other.** We are also a party to various other legal actions arising out of the normal course of our business. Due to the inherent uncertainties of litigation and dispute resolution, we are unable to estimate the ultimate losses, if any, relating to each of our outstanding legal actions and other loss contingencies.

Also see "Critical Accounting Policies and Estimates – Professional Liability Risks" in Item 7 of Part II and Note 13 to the Consolidated Financial Statements in Item 8 of Part II.

#### **Item 4. Mine Safety Disclosures.**

Not applicable.

## **PART II**

#### **Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.**

The common stock of Health Management Associates, Inc. (together with its subsidiaries hereinafter referred to as "we," "our" or "us") is listed on the New York Stock Exchange under the symbol "HMA." As of February 17, 2012, there were 254,435,258 shares of our common stock held by approximately 900 record holders. The table below sets forth the high and low sales prices per share of our common stock on the New York Stock Exchange for each of the quarters during the years ended December 31, 2011 and 2010.

	<u>High</u>	<u>Low</u>
Year ended December 31, 2011:		
First quarter	\$ 11.07	\$ 8.86
Second quarter	11.74	9.82
Third quarter	11.26	6.43
Fourth quarter	9.26	6.06
Year ended December 31, 2010:		
First quarter	\$ 9.12	\$ 6.49
Second quarter	9.81	7.72
Third quarter	7.93	6.13
Fourth quarter	9.88	7.19

The debt agreements that we entered into as part of a long-term debt restructuring that was completed on November 18, 2011 (the "2011 Debt Restructuring") and the indentures for certain of our other debt agreements restrict our ability to pay cash dividends. Further discussion of the 2011 Debt Restructuring and our long-term debt arrangements can be found at Note 2 to the Consolidated Financial Statements in Item 8.

At December 31, 2011, we had reserved a sufficient number of shares to satisfy the potential conversion of our convertible senior subordinated notes, which are discussed at Note 2(c) to the Consolidated Financial Statements in Item 8.

The table below summarizes the number of shares of our common stock that were withheld to satisfy the tax withholding obligations for our stock-based compensation awards that vested during the three months ended December 31, 2011.

<u>Month Ended</u>	<u>Total Number of Shares Purchased</u>	<u>Average Price Per Share</u>
October 31, 2011	-	\$ -
November 30, 2011	-	-
December 31, 2011	18,969	8.27
Total	<u>18,969</u>	

#### **Item 6. Selected Financial Data.**

The table on the following page summarizes certain of our selected financial data and should be read in conjunction with the Consolidated Financial Statements and accompanying notes in Item 8. Certain amounts in the table have been reclassified in the prior years to conform to the current year presentation. Such reclassifications related to discontinued operations, which are discussed at Note 10 to the Consolidated Financial Statements.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**FIVE YEAR SUMMARY OF SELECTED FINANCIAL DATA**  
(in thousands, except per share amounts)

	Years Ended December 31,				
	2011	2010	2009	2008	2007
Net revenue (1)	\$ 5,804,451	\$ 5,092,166	\$ 4,536,106	\$ 4,278,604	\$ 4,103,404
Income from continuing operations (1) (2) (3)	206,334	185,774	161,303	210,515	117,438
Income (loss) from discontinued operations, net of income taxes (3) (4)	(2,409)	(13,526)	2,638	(26,358)	396
Net income attributable to Health Management Associates, Inc. (2) (4)	178,710	150,069	138,182	168,149	117,508
Income from continuing operations attributable to Health Management Associates, Inc. common stockholders (per share-diluted)	\$ 0.71	\$ 0.65	\$ 0.55	\$ 0.80	\$ 0.48
Weighted average number of shares outstanding - diluted	255,037	251,106	246,965	244,671	245,119
Cash dividends per common share (5)	\$ -	\$ -	\$ -	\$ -	\$ 10.00

	December 31,				
	2011	2010	2009	2008	2007
Total assets	\$ 6,004,189	\$ 4,910,085	\$ 4,604,099	\$ 4,554,232	\$ 4,633,512
Long-term debt and capital lease obligations (5)	3,574,998	3,018,464	3,040,661	3,206,834	3,770,057
Redeemable equity securities	200,643	201,487	182,473	48,868	19,306
Stockholders' equity, including noncontrolling interests (5)	785,116	533,486	361,620	285,811	71,836

- (1) Amounts exclude our discontinued operations, which are identified at Note 10 to the Consolidated Financial Statements in Item 8.
- (2) In connection with the 2011 Debt Restructuring, income from continuing operations for the year ended December 31, 2011 included (i) approximately \$24.6 million of write-offs of deferred debt issuance costs and related other and (ii) \$16.4 million of amortization and net fair value adjustment expense that is attributable to our interest rate swap contract. See Note 2 to the Consolidated Financial Statements in Item 8 for information regarding the 2011 Debt Restructuring and our long-term debt arrangements. Also included in income from continuing operations during 2011 were: (i) a \$40.0 million first time benefit from the meaningful use measurement standard under various Medicare and Medicaid Healthcare Information Technology ("HCIT") incentive programs; (ii) \$12.9 million of expenses attributable to restructuring activities at Tennova Healthcare; and (iii) \$9.5 million of costs for acquisitions and government investigations. See Notes 4 and 13 to the Consolidated Financial Statements in Item 8 for more information about certain of these matters. Income from continuing operations for the year ended December 31, 2008 included a gain of \$161.4 million from the sale of a noncontrolling interest in our joint venture with Novant Health, Inc. and one or more of its affiliates (collectively, "Novant"). Additionally, income from continuing operations for the years ended December 31, 2009 and 2008 included net gains on the early extinguishment of debt of \$16.2 million and \$15.2 million, respectively.
- (3) Income from continuing operations for the years ended December 31, 2011, 2010, 2009, 2008 and 2007 included amounts attributable to noncontrolling interests of approximately \$25.2 million, \$22.2 million, \$25.0 million, \$16.1 million and \$0.8 million, respectively. The corresponding amounts for discontinued operations were not material to the years presented.
- (4) The loss from discontinued operations for the year ended December 31, 2011 included a goodwill impairment charge of approximately \$3.6 million from the termination of a lease agreement in respect of our hospital in Marathon, Florida. The loss from discontinued operations for the year ended December 31, 2010 included (i) a loss of \$12.1 million from the sale of our general acute care hospital in Meridian, Mississippi and its related health care operations and (ii) a long-lived asset impairment charge of \$8.4 million. Income from discontinued operations for the year ended December 31, 2009 included (i) a gain of \$10.4 million from the restructuring of our joint venture with Novant and (ii) long-lived asset impairment charges of \$4.6 million. See Notes 4 and 10 to the Consolidated Financial Statements in Item 8 for information regarding Novant and our discontinued operations, respectively. The loss from discontinued operations for the year ended December 31, 2008 included: (i) long-lived asset and goodwill impairment charges of \$38.0 million; (ii) a gain of \$42.0 million from the sale of a noncontrolling interest in our joint venture with Novant; and (iii) a charge of \$7.9 million for the estimated cost of partially subsidizing certain third party physician practice losses. Income from discontinued operations for the year ended December 31, 2007 included a gain of \$21.8 million from the sale of two Virginia-based general acute care hospitals and certain affiliated health care entities.
- (5) The 2011 Debt Restructuring, which is discussed at Note 2 to the Consolidated Financial Statements in Item 8, was completed on November 18, 2011. In connection with a recapitalization of our balance sheet, a special cash dividend of \$10.00 per common share was paid during the year ended December 31, 2007. The special cash dividend, which aggregated approximately \$2.43 billion, was financed through borrowings under our former credit facilities.

## **Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.**

### **Forward-Looking Statements**

Certain statements contained in this Annual Report on Form 10-K, including, without limitation, statements containing the words "believe," "anticipate," "intend," "expect," "may," "could," "plan," "continue," "should," "project," "estimate" and words of similar import, constitute "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended. These statements may include projections of revenue, provisions for doubtful accounts, income or loss, capital expenditures, debt structure, principal payments on debt, capital structure, the amount and timing of funds under the meaningful use measurement standard of various Healthcare Information Technology ("HCIT") incentive programs, other financial items and operating statistics, statements regarding our plans and objectives for future operations, acquisitions, acquisition financing, divestitures and other transactions, statements of future economic performance, statements regarding our legal proceedings and other loss contingencies, statements regarding market risk exposures, statements regarding the effects and/or interpretations of recently enacted or future health care laws and regulations, statements of the assumptions underlying or relating to any of the foregoing statements, and statements that are other than statements of historical fact.

Forward-looking statements are based on our current plans and expectations and involve known and unknown risks, uncertainties and other factors that may cause our actual results, performance, achievements or industry results to be materially different from any future results, performance or achievements expressed or implied by our forward-looking statements. Such factors include, among other things, the risks and uncertainties identified by us under the heading "Risk Factors" in Item 1A of Part I. Furthermore, we operate in a continually changing business and regulatory environment and new risk factors emerge from time to time. We cannot predict what these new risk factors may be, nor can we assess the impact, if any, of such new risk factors on our business or results of operations or the extent to which any factor or combination of factors may cause our actual results to differ materially from those expressed or implied by any of our forward-looking statements.

Undue reliance should not be placed on our forward-looking statements. Except as required by law, we disclaim any obligation to update our risk factors or to publicly announce updates to the forward-looking statements contained in this Annual Report on Form 10-K to reflect new information, future events or other developments.

### **Critical Accounting Policies and Estimates**

The preparation of financial statements in conformity with U.S. generally accepted accounting principles ("GAAP") requires us to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes. We consider the following critical accounting policies to be those that require us to make significant judgments and estimates when we prepare our consolidated financial statements.

#### ***Net Revenue***

We derive a significant portion of our net revenue from Medicare, Medicaid and managed care health plans. Payments for services rendered to patients covered by these programs are generally less than billed charges. For Medicare and Medicaid, provisions for contractual adjustments are made to reduce patient charges to the estimated cash receipts based on each program's principles of payment/reimbursement (i.e., either prospectively determined or retrospectively determined costs). Final settlements under these programs are subject to administrative review and audit and, accordingly, we periodically provide reserves for the adjustments that may ultimately result therefrom. Estimates for contractual allowances under managed care health plans are primarily based on the payment terms of contractual arrangements, such as predetermined rates per diagnosis, per diem rates or discounted fee for service rates. We closely monitor our historical collection rates, as well as changes in applicable laws, rules and regulations and contract terms, to ensure that provisions are made using the most accurate information available. However, due to the complexities involved in these estimations, actual payments from payors may be different from the amounts we estimate and record. If the actual contractual reimbursement percentage under government programs and managed care contracts differed by 1% from our estimated percentage, we project that our net accounts receivable and consolidated net income as of and for the year ended December 31, 2011 would have changed by approximately \$28.4 million and \$17.4 million, respectively.

In the ordinary course of business, we provide services to patients who are financially unable to pay for their care. Accounts characterized as charity and indigent care are not recognized in net revenue. We maintain a uniform policy whereby patient account balances are characterized as charity and indigent care only if the patient meets certain percentages of the federal poverty level guidelines. Local hospital personnel and our collection agencies pursue payments on accounts receivable from patients who do not meet such criteria. We monitor the levels of charity and indigent care provided by our hospitals and other health care facilities and the procedures employed to identify and account for those patients.

### ***Provision for Doubtful Accounts***

Our hospitals and other health care facilities provide services to patients with health care coverage, as well as to those without health care coverage. Those patients with health care coverage are often responsible for a portion of their bill referred to as the co-payment or deductible. This portion of the bill is determined by the patient's individual health care or insurance plan. Patients without health care coverage are evaluated at the time of service, or shortly thereafter, for their ability to pay based on federal and state poverty guidelines, qualification for Medicaid or other state assistance programs, as well as our policies for indigent and charity care. After payment, if any, is received from a third party, statements are sent to patients indicating the outstanding balances on their accounts. If an account is still outstanding after a period of time, it is referred to a primary collection agency for assistance in collecting the amount due. The primary collection agency begins the process of debt collection by contacting the patient via mail and phone. The accounts that are sent to these agencies are often difficult to collect and require more focused, dedicated attention than might be available in one of our business offices. We believe that the primary collection agencies have been very successful in collecting the accounts that we send to them. A secondary collection agency is used when accounts are returned from the primary collection agency as uncollectible. These accounts are written off as uncollectible shortly after they are returned to us from the primary collection agency. In certain circumstances, we may sell a portfolio of outstanding accounts receivable to an unrelated third party.

An account is typically sent to the primary collection agency automatically via electronic transfer of data at the end of the statement cycle although, if deemed necessary or appropriate, the account can be sent to the primary collection agency at any time. Accounts that are identified as self-pay accounts with balances less than \$9.99 are automatically written off on the 20<sup>th</sup> day of each month. All accounts that have been placed with a primary collection agency that are less than \$25.00 are also written off.

When considering the adequacy of our allowance for doubtful accounts, accounts receivable balances are routinely reviewed in conjunction with health care industry trends/indicators, historical collection rates by payor, aging reports and other business and economic conditions that might reasonably be expected to affect the collectibility of patient accounts. We believe that our principal risk of collection continues to be uninsured patient accounts and patient accounts for which the primary insurance payor has paid but patient responsibility amounts (generally deductibles and co-payments) remain outstanding. If our actual collection rate changed by 1% from the estimated percentage that we used, we project that our allowance for doubtful accounts and consolidated net income as of and for the year ended December 31, 2011 would have changed by approximately \$5.8 million and \$3.5 million, respectively.

Although we believe that our existing allowance for doubtful accounts reserve policies for all payor classes are appropriate and responsive to both the current health care environment and the overall economic climate, we will continue to monitor cash collections, accounts receivable agings and related industry trends. Changes in payor mix, general economic conditions or federal and state government health care coverage, including the effects of the Health Care Reform Act, could each have a material adverse effect on our accounts receivable collections, cash flows and results of operations and could result in accounting policy modifications in the future.

Of the accounts receivable identified as due from third party payors at the time of billing, a small percentage may convert to self-pay upon denials from third party payors. Those accounts are closely monitored on a routine basis for potential denial and are reclassified as appropriate. Third party payor and self-pay balances, as a percent of total gross billed accounts receivable, are summarized in the tables below.

December 31, 2011				
	0-180 days	181-240 days	241-300 days	301 days and over
Medicare	16%	-%	-%	-%
Medicaid	13	1	1	-
Commercial insurance and others	41	2	1	1
Self-pay	13	4	4	3
Totals	83%	7%	6%	4%
December 31, 2010				
	0-180 days	181-240 days	241-300 days	301 days and over
Medicare	17%	-%	-%	-%
Medicaid	12	1	-	-
Commercial insurance and others	38	2	1	1
Self-pay	15	5	5	3
Totals	82%	8%	6%	4%

Accounts receivable are reserved at increasing percentages as they age. All accounts are reserved 100% when they age 300 days from the date of discharge. In addition to days sales outstanding, which is discussed below under "Liquidity, Capital Resources and Capital Expenditures," we use other factors to analyze the collectibility of our accounts receivable. In that regard, we compare subsequent cash collections to net accounts receivable recorded on our consolidated balance sheet. We also review the provision for doubtful accounts as a percent of net revenue and the allowance for doubtful accounts as a percent of gross accounts receivable. These and other factors are reviewed monthly and are closely monitored for emerging trends in our accounts receivable portfolio.

### ***Impairments of Long-Lived Assets and Goodwill***

**Long-lived assets.** We review our long-lived assets, including amortizable intangible assets, for impairment whenever events or changes in circumstances indicate that the carrying amount of those assets may not be fully recoverable (e.g., advances in technology, deteriorating operating results, excess capacity, obsolescence, etc.). The determination of possible impairment of assets to be held and used is predicated on our estimate of the asset's undiscounted future cash flows. If the estimated future cash flows are less than the carrying value of the asset, an impairment charge is recognized for the difference between the asset's estimated fair value and its carrying value. Long-lived assets to be disposed of, including discontinued operations, are reported at the lower of their carrying amount or estimated fair value, less costs to sell. Estimates of fair value are based on recent sales of similar assets, market analyses, pending disposition transactions and market responses based on discussions with, and offers received from, potential buyers. There were no long-lived asset impairment charges that were material to our continuing operations during the years ended December 31, 2011, 2010 and 2009; however, as discussed at Note 10 to the Consolidated Financial Statements in Item 8, we recognized long-lived asset charges of approximately \$8.4 million and \$4.6 million in discontinued operations during 2010 and 2009, respectively.

**Goodwill.** Goodwill is reviewed for impairment on an annual basis (i.e., each October 1) and whenever circumstances indicate that a possible impairment might exist. Our judgment regarding the existence of impairment indicators is based on, among other things, market conditions and operational performance. When performing goodwill impairment tests prior to 2011, we initially compared the estimated fair values of each reporting unit's net assets, including allocated home office net assets, to the corresponding carrying amounts on our consolidated balance sheet. The estimated fair values of our reporting units were determined using a market approach methodology based on net revenue multiples. We also considered a valuation methodology using discounted cash flows and a market approach valuation methodology based on comparable transactions. If the estimated fair value of a reporting unit's net assets was less than the balance sheet carrying amount, we determined the implied fair value of the reporting unit's goodwill, compared such fair value to the corresponding carrying amount and, if necessary, recorded a goodwill impairment charge.

During September 2011, the Financial Accounting Standards Board amended the accounting standards in GAAP as they relate to the annual test for goodwill impairment (the "Goodwill Update"). The Goodwill Update allows, but does not require, an initial assessment of qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount for the purpose of determining if detailed quantitative goodwill impairment testing is necessary. We elected to early adopt the Goodwill Update in connection with our annual goodwill impairment testing on October 1, 2011. Our adoption of the Goodwill Update did not have a material impact on our annual goodwill impairment testing or the results therefrom. Specifically, the qualitative factors reviewed by us did not reveal any circumstances whereby detailed quantitative goodwill impairment testing was necessary at the reporting unit level. There were no goodwill impairment charges in continuing operations during the years ended December 31, 2011, 2010 and 2009; however, as discussed at Note 10 to the Consolidated Financial Statements in Item 8, we recognized a goodwill impairment charge of approximately \$3.6 million in discontinued operations during 2011. We do not believe that any of our reporting units are currently at risk of incurring a goodwill impairment charge.

Qualitative assessments of our reporting units are based on estimates and assumptions that we believe to be reasonable but are ultimately unpredictable and inherently uncertain. Additionally, we make certain judgments and assumptions when allocating home office assets and liabilities to determine the carrying values of our reporting units. Changes in the estimates, assumptions and other qualitative factors used to conduct goodwill impairment tests, including revenue and profitability projections and market values, could indicate that our goodwill is impaired in future periods and result in a write-off of some or all of our goodwill at that time. Reporting units are one level below the operating segment level (see Note 1(m) to the Consolidated Financial Statements in Item 8). However, after consideration of the relevant GAAP aggregation rules, we determined that our goodwill impairment testing should be performed at the divisional operating level. Goodwill is discretely allocated to our reporting units (i.e., each hospital's goodwill is included as a component of the aggregate reporting unit goodwill being evaluated during the impairment analysis).

### ***Income Taxes***

We make estimates to record the provision for income taxes, including conclusions regarding deferred tax assets and deferred tax liabilities, as well as valuation allowances that might be required to offset deferred tax assets. We estimate valuation allowances to reduce deferred tax assets to the amounts that we believe are more likely than not to be realized in future periods. When establishing valuation allowances, we consider all relevant information, including ongoing tax planning strategies. We believe that, other than certain state net operating loss carryforwards, reversals of existing taxable temporary differences, future taxable income and carrybacks will enable us to realize our deferred tax assets and, therefore, we have not recorded any material valuation allowances against our deferred tax assets.

We operate in multiple states with varying tax laws. We are subject to both federal and state audits of our tax filings. Our federal income tax returns have been examined by the Internal Revenue Service through the period ended December 31, 2009. We participate in the Internal Revenue Service's Compliance Assurance Program whereby our federal income tax returns will be audited on a concurrent basis. The Internal Revenue Service is currently auditing our income tax return for the year ended December 31, 2010. We make estimates to record tax reserves that we believe adequately provide for audit adjustments, if any.

### ***Professional Liability Risks***

As with most other health care providers, we are subject to claims and legal actions by patients and others in the ordinary course of business. We use our wholly owned captive insurance subsidiary and our risk retention group subsidiary, which are domiciled in the Cayman Islands and South Carolina, respectively, to self-insure a significant portion of our professional liability risks. Those subsidiaries, which are collectively referred to as the "Insurance Subsidiaries," provide (i) claims-made coverage to all of our hospitals and other health care facilities and (ii) occurrence-basis coverage to most of our employed physicians. To mitigate the exposure of the self-insured program covering the hospitals and other health care facilities, the Insurance Subsidiaries buy claims-made reinsurance policies from unrelated third parties for claims above self-retention levels of \$10.0 million or \$15.0 million, depending on the policy year. The limits of liability provided by the Insurance Subsidiaries for each employed physician located outside of Florida is generally \$1 million per claim and \$3 million in the aggregate, and the corresponding limits for physicians located in Florida are \$250,000 and \$750,000, respectively. Our employed physicians not covered by the Insurance Subsidiaries generally maintain claims-made policies with unrelated third party insurance companies.

Our self-insured professional liability reserves reflect estimates of all known indemnity losses, incurred but not reported indemnity losses and related incurred/future loss expenses. As of December 31, 2011 and 2010, such discounted reserves, net of amounts estimated to be recoverable under reinsurance policies, were approximately \$215.6 million and \$180.9 million, respectively. Included in those amounts were \$53.7 million and \$61.3 million, respectively, of case reserves on reported claims. Historically, the average lag time between settlement of a claim and payment to the claimant is generally less than one month. Therefore, our total unpaid settled claim amount at the end of any reporting period is not significant. Our expense for professional liability risks includes: (i) an estimate of discounted losses and loss expenses for the current year, including claims incurred but not reported; (ii) changes in estimates for losses and loss expenses from prior years based on actual claim development experience; (iii) interest accretion on discounted reserves; and (iv) cumulative adjustments for changes in the discount rate, if any, during the year. Such expense was \$66.3 million, \$68.6 million and \$60.5 million during the years ended December 31, 2011, 2010 and 2009, including \$66.4 million, \$52.2 million and \$49.9 million, respectively, relating to current year claim activity. The year-over-year increases in our expense for current year claim activity reflect, among other things, organic and acquisition-related growth in our business.

Our reserves for self-insured professional liability risks are determined using actuarially-based techniques and methodologies. The data used to develop such reserves is based, in part, on asserted and unasserted claim information that has been accumulated by our incident reporting system. In the consolidated financial statements, these long-term liabilities are recorded at their estimated present values using a discount rate of 1.00% at both December 31, 2011 and 2010. We select a discount rate that represents a risk-free interest rate correlating to the period when the claims are projected to be paid (i.e., a weighted average payment duration of approximately three years). However, the facts and circumstances of each individual claim can result in an occurrence-to-settlement interval that varies from our payment duration estimate. As of December 31, 2011, a 25 basis point increase or decrease in the discount rate would have changed our professional liability reserve requirements by approximately \$1.4 million.

For purposes of estimating case reserves, we use individual claim information, including the nature of the claim, the expected claim amount, payments made on the claim to date, the year in which the claim occurred and the laws of the jurisdiction where the incident occurred. Once case reserves for known claims are determined, the data is stratified by loss layers and retention levels, accident years, reported years, geography and other key attributes. Several actuarial methods are applied to the data by us and our external actuaries on a semi-annual basis to produce estimates of the ultimate indemnity losses and related loss expenses for both known and incurred but not reported claims. Such actuarial methods include: (i) paid and incurred extrapolation methods; (ii) frequency and severity methods to estimate the ultimate average frequency (number of claims) and the ultimate average severity (cost per claim); and (iii) Bornhuetter-Ferguson methods that add expected development to actual paid or incurred experience. Each of these actuarial methods uses our company-specific data, including: historical paid indemnity losses and loss expenses that have been accumulated over a period of fifteen years; current and historical case reserves; actual and projected census data; employed physician information; our professional liability retention levels by policy year; geographic information; trends of loss development factors; trends in the frequency and severity of claims; coverage limits of unrelated third party insurance policies; and other relevant inputs. We also consider pertinent industry data and changes in laws and regulations (e.g., tort reform, settlement caps, etc.) in the jurisdictions where our hospitals and other health care facilities operate. We believe that using the aforementioned company-specific data and other information enables us and our external actuaries to reasonably estimate (i) our ultimate indemnity losses and related loss expenses and (ii) the projected timing of the corresponding payments. Therefore, we further believe that discounting our self-insured professional liability reserves is appropriate.

Given the number of factors used to establish our reserves for self-insured professional liability risks, we believe that there is limited benefit to isolating any individual assumption or parameter from the detail computational process and calculating the impact of changing that single item. Instead, we believe that the sensitivity of the estimates of such reserves is best reflected in the selected actuarial confidence level used in the computations. In our actuarial modeling, we consistently used the central estimate, which generally approximates a confidence level at the 50<sup>th</sup> percentile. Utilizing a confidence level higher than the central estimate, while not representative of our best estimate, would reflect a reasonably likely outcome for the ultimate resolution of our known and incurred but not reported indemnity claims and related expenses. For example, using a statistical confidence level at the 70<sup>th</sup> percentile in our actuarial model would increase our discounted net reserves by approximately \$23.0 million, or 10.7%.

Our reserves for self-insured professional liability risks are periodically reviewed and adjustments thereto are recorded as more information about claim trends becomes known to us. Although the ultimate settlement of these liabilities may vary from our estimates due to, among other things, their inherently complex, long-term and subjective nature, we believe that the amounts included in the consolidated financial statements are adequate and reasonable. However, if actual losses and loss expenses exceed our projections of claim activity and/or the projected claim payment duration differs from our estimates, our reserves could be materially impacted.

#### ***Other Self-Insured Programs***

We provide (i) income continuance to, and reimburse certain health care costs of, our disabled employees (collectively, "workers' compensation") and (ii) health and welfare benefits to our employees, their spouses and certain beneficiaries. Such employee benefit programs are primarily self-insured; however, we purchase stop-loss insurance policies from unrelated third parties to mitigate our exposure to catastrophic events and individual years with high levels of benefit claim activity. We record estimated liabilities for both reported and incurred but not reported workers' compensation and health and welfare claims based on historical loss experience and other information provided by our third party administrators. The long-term liabilities for workers' compensation are determined using actuarially-based techniques and methodologies and are discounted to their estimated present values. We select a discount rate that represents a risk-free interest rate correlating to the period when such benefits are projected to be paid. As of December 31, 2011, a 25 basis point increase or decrease in the discount rate would have changed our net workers' compensation liability by approximately \$0.5 million (our net liability considers discounted receivables for amounts that are estimated to be recoverable under stop loss insurance policies). Although there can be no assurances, we believe that the net liabilities included in the consolidated financial statements for these self-insured programs are adequate and reasonable. If the actual costs of these programs exceed our projections and/or the projected period over which workers' compensation benefits will be paid differs from our estimates, the net liabilities could be materially adversely affected.

### ***Loss Contingencies***

We regularly review the status of our legal and regulatory matters and assess the potential financial exposure thereof. If the potential loss from any claim, lawsuit or regulatory proceeding is considered probable and the amount can be reasonably estimated, we record a reserve. Attorneys' fees and other costs of defending our company in respect of claims, lawsuits and regulatory proceedings are expensed in the period such fees and costs are incurred, except for those amounts relating to our professional liability risks, which are discussed at Note 1(h) to the Consolidated Financial Statements in Item 8. Significant judgment is required when determining probability and whether an exposure is reasonably estimable. Predicting the final resolution of claims, lawsuits and regulatory matters and estimating financial exposure requires consideration of substantial uncertainties and, therefore, the actual costs thereof may vary significantly from our estimates. When making determinations of likely outcomes of legal and regulatory matters and the related financial exposure, we consider many factors, including, but not limited to, the nature of the claim (including unasserted claims), the availability of insurance, our experience with similar types of claims, the jurisdiction where the matter is being adjudicated, input from in-house and external legal counsel, the likelihood of resolution through alternative dispute resolution or other means and the current status of the matter. As additional information becomes available, we reassess our potential liability and we may revise and adjust our estimates at that time. Adjustments to reserves reflect the status of negotiations, settlements, rulings, advice of legal counsel and other relevant information. Changes in our estimates of financial exposure for legal matters and other loss contingencies could have a material impact on our consolidated financial position and results of operations. See Note 13 to the Consolidated Financial Statements in Item 8 for information regarding our material legal matters and other loss contingencies.

### ***Recent Accounting Standards Updates***

See Note 1(e) and Note 12 to the Consolidated Financial Statements in Item 8 for a discussion of recent accounting standards updates that we adopted during the year ended December 31, 2011 or that we will adopt during the quarter ending March 31, 2012. We do not believe that such new accounting guidance had or will have a material impact on us.

## **Results of Operations**

### ***2011 Overview***

The following discussion and analysis should be read in conjunction with the Consolidated Financial Statements and the accompanying notes in Item 8.

As of December 31, 2011, we operated 66 hospitals by and through our subsidiaries with a total of 10,330 licensed beds in non-urban communities in Alabama, Arkansas, Florida, Georgia, Kentucky, Mississippi, Missouri, North Carolina, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Washington and West Virginia. See Note 10 to the Consolidated Financial Statements in Item 8 for information about one of our Tennessee-based hospitals with a lease agreement that will expire in May 2012 and will not be renewed. Also, see Note 15 for information about our pending acquisition of an 80% equity interest in each of five Oklahoma-based general acute care hospitals and their related health care operations, which we plan to complete during the quarter ending June 30, 2012. The operating results of hospitals and other ancillary health care businesses that we acquire are included in our consolidated financial statements subsequent to the date of acquisition.

Unless specifically indicated otherwise, the following discussion excludes our discontinued operations, which are identified at Note 10 to the Consolidated Financial Statements in Item 8. Such discontinued operations were not material to our consolidated results of operations during the years presented herein, other than the following items: (i) a 2010 loss of approximately \$12.1 million from the sale of Riley Hospital in Meridian, Mississippi and its related health care operations; (ii) 2011, 2010 and 2009 long-lived asset and goodwill impairment charges of \$3.6 million, \$8.4 million and \$4.6 million, respectively; and (iii) a 2009 gain of \$10.4 million from the sale of equity interests in a limited liability company that owned and operated two of our general acute care hospitals.

During March 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Health Care Reform Act") were signed into law by President Obama. The primary goals of the Health Care Reform Act are to: (i) provide coverage by January 1, 2014 to an estimated 32 to 34 million Americans who currently do not have health insurance; (ii) reform the health care delivery system to improve quality; and (iii) lower the overall costs of providing health care. To accomplish the goal of expanding coverage, the new legislation mandates that all Americans maintain a minimum level of health care coverage. To that end, the Health Care Reform Act expands Medicaid coverage, provides federal subsidies to assist low-income

individuals when they obtain health insurance and establishes insurance exchanges through which individuals and small employers can purchase health insurance. Health care cost savings under the Health Care Reform Act are expected to come from: (i) reductions in Medicare and Medicaid reimbursement payments to health care providers, including hospital operators; (ii) initiatives to reduce fraud, waste and abuse in government reimbursement programs; and (iii) other reforms to federal and state reimbursement systems. Although certain aspects of the Health Care Reform Act have already become effective, it will be several years before most of the far-reaching and innovative provisions of the new legislation are fully implemented. While we continue to evaluate the provisions of the Health Care Reform Act, its overall effect on our business cannot be reasonably determined at the present time because, among other things, the new legislation is very broad in scope and there exist uncertainties regarding the interpretation and future implementation of many of the regulations mandated under the Health Care Reform Act. Additionally, the Health Care Reform Act remains subject to significant legislative debate, including possible repeal and/or amendment, and there are substantial legal challenges to various aspects of the law that have been made on constitutional grounds, including an appeal currently pending before the United States Supreme Court (a ruling is expected by July 2012). For further discussion of the Health Care Reform Act and its possible impact on our business and results of operations, see "Business – Sources of Revenue" in Item 1 of Part I and "Risk Factors" in Item 1A of Part I.

During the year ended December 31, 2011, which we refer to as the 2011 Calendar Year, we experienced net revenue growth over the year ended December 31, 2010, which we refer to as the 2010 Calendar Year, of approximately 14.0%. Such growth principally resulted from: (i) our acquisition of a 60% equity interest in each of three Florida-based general acute care hospitals with a total of 139 licensed beds and certain related health care operations (collectively, "Shands") in July 2010; (ii) our acquisition of two Florida-based general acute care hospitals with a total of 413 licensed beds and certain related health care operations (collectively, "Wuesthoff") in October 2010; (iii) our acquisition of a 95% equity interest in a Mississippi-based general acute care hospital with a total of 112 licensed beds and certain related health care operations (collectively, "Tri-Lakes") in May 2011; (iv) our acquisition of six Tennessee-based general acute care hospitals and other ancillary health care operations with a total of 882 licensed beds (collectively, the "Mercy Hospitals") on September 30, 2011; (v) increased surgical volume attributable to physician recruitment and market service development (e.g., ambulatory surgical centers, robotic surgical systems, etc.) at certain of our hospitals and other health care facilities; (vi) more emergency room visits, which we believe were attributable, in part, to our dedicated focus on emergency room operations; and (vii) improvements in reimbursement rates that resulted primarily from renegotiated agreements with certain commercial health insurance providers. During the 2011 Calendar Year, we recorded a first time benefit of approximately \$40.0 million from the meaningful use measurement standard under various Medicare and Medicaid Healthcare Information Technology incentive programs (collectively, the "HCIT Programs"). Items that adversely affected our profitability during the 2011 Calendar Year included: (i) increases in interest expense and costs for government investigations; (ii) \$24.6 million of write-offs of deferred debt issuance costs and related other attributable to a debt restructuring that we completed on November 18, 2011 (the "2011 Debt Restructuring"); and (iii) expenses attributable to our acquisition of the Mercy Hospitals and related restructuring activities. Overall, our income from continuing operations increased during the 2011 Calendar Year by \$20.6 million, or 11.1%.

Our strategic operational objectives include increasing patient volume and operating margins, while decreasing uninsured/underinsured patient levels and the provision for doubtful accounts. Our specific plans include, among other things, utilizing experienced local and regional management teams, modifying physician employment agreements, renegotiating payor and vendor contracts and developing action plans responsive to feedback from patient, physician and employee satisfaction surveys. Based on the needs of the communities that we serve, we also seek opportunities for market service development, including establishing ambulatory surgical centers, urgent care centers, cardiac cath labs, angiography suites and orthopedic, cardiology and neurology/neurosurgery centers of excellence. Furthermore, we are investing significant resources in physician recruitment and retention (primary care physicians and specialists), emergency room operations, advanced robotic surgical systems, replacement hospital construction and other capital projects. For example, we continue to implement ER Extra®, which is our signature patient-centered emergency room program that is designed to reduce patient wait times, enhance patient satisfaction and improve the quality and scope of patient assessments. During 2011, we also opened a hospital that we built to replace Madison County Medical Center in Canton, Mississippi and deployed new MAKOpasty® and da Vinci® robotic surgical systems at many of our hospitals. We believe that our strategic initiatives, coupled with appropriate executive management oversight, centralized support and innovative marketing campaigns, will enhance patient, physician and employee satisfaction, improve clinical outcomes and ultimately yield increased surgical volume, emergency room visits and admissions. Additionally, as we consider potential acquisitions, joint ventures and partnerships in 2012 and beyond, we believe that continually improving our existing operations provides us with a fundamentally sound infrastructure upon which we can add hospitals and other ancillary health care businesses.

We have also taken steps that we believe are necessary to achieve industry leadership in clinical quality. Our vision is to be the highest rated health care provider of any hospital system in the country, as measured by Medicare. With our knowledgeable and experienced clinical affairs leadership supporting this critical quality initiative, we measure key performance objectives, maintain accountability for achieving those objectives and recognize the leaders whose quality indicators and clinical outcomes demonstrate improvement. As most recently reported by the Centers for Medicare and Medicaid Services, all four of our core measure care areas have dramatically improved since the commencement of our clinical quality initiatives and we now rank second in core measures amongst for-profit hospital systems. Additionally, The Joint Commission, a leading independent not-for-profit organization that accredits and certifies health care organizations in the United States, recently named nearly 60% of our hospitals as Top Performers on Key Quality Measures, which compares to a nationwide achievement rate of approximately 14%. The Joint Commission aggregated certain evidence-based accountability data from 2010, including core measurement performance data, to determine the top performers.

Outpatient services continue to play an important role in the delivery of health care in our markets, with approximately half of our net revenue generated on an outpatient basis. Recognizing the importance of these services, we have improved many of our health care facilities to accommodate the outpatient needs of the communities that they serve. We have also invested substantial capital in many of our hospitals and physician practices during the past several years, resulting in improvements and enhancements to our diagnostic imaging and ambulatory surgical services.

During the past several years, various economic and other factors have resulted in a large number of uninsured and underinsured patients seeking health care in the United States. Self-pay admissions as a percent of total admissions at our hospitals were approximately 6.7% and 7.1% during the 2011 Calendar Year and the 2010 Calendar Year, respectively. We continue to take various measures to address the impact of uninsured and underinsured patients on our business. Additionally, one of the primary goals of the Health Care Reform Act is to provide health insurance coverage to more Americans. Nevertheless, there can be no assurances that our self-pay admissions will not grow in future periods, especially in light of the prolonged downturn in the economy and correspondingly higher levels of unemployment in many of the markets served by our hospitals. Therefore, we regularly evaluate our self-pay policies and programs and consider changes or modifications as circumstances warrant.

### *2011 Calendar Year Compared to the 2010 Calendar Year*

The tables below summarize our operating results for the 2011 Calendar Year and the 2010 Calendar Year. Hospitals that were owned/leased and operated by us for one year or more as of December 31, 2011 are referred to as same 2011 hospitals. For all year-over-year comparative discussions herein, the operating results of our same 2011 hospitals are only considered to the extent that there was a similar period of operation in both years.

	Years Ended December 31,			
	2011		2010	
	Amount (in thousands)	Percent of Net Revenue	Amount (in thousands)	Percent of Net Revenue
Net revenue	\$ 5,804,451	100.0%	\$ 5,092,166	100.0%
Salaries and benefits	2,302,844	39.7	2,016,967	39.6
Supplies	776,598	13.4	703,426	13.8
Provision for doubtful accounts	716,856	12.4	624,753	12.3
Rent expense	154,279	2.6	122,983	2.4
Other operating expenses	1,067,980	18.4	892,465	17.5
Medicare and Medicaid HCIT incentive payments	(39,982)	(0.7)	-	-
Depreciation and amortization	267,900	4.6	241,873	4.8
Interest expense	222,747	3.8	211,673	4.2
Write-offs of deferred debt issuance costs and related other	24,595	0.4	-	-
Other	(1,771)	-	(8,797)	(0.2)
	<u>5,492,046</u>	<u>94.6</u>	<u>4,805,343</u>	<u>94.4</u>
Income from continuing operations before income taxes	312,405	5.4	286,823	5.6
Provision for income taxes	(106,071)	(1.8)	(101,049)	(2.0)
Income from continuing operations	<u>\$ 206,334</u>	<u>3.6%</u>	<u>\$ 185,774</u>	<u>3.6%</u>

**2011 Calendar Year Compared to the 2010 Calendar Year (continued)**

	Years Ended December 31,		Change	Percent Change
	2011	2010		
Same 2011 Hospitals*				
Occupancy	42.1%	43.9%	(180) bps**	n/a
Patient days	1,300,722	1,350,697	(49,975)	(3.7)%
Admissions	311,053	323,917	(12,864)	(4.0)%
Adjusted admissions †	581,056	586,060	(5,004)	(0.9)%
Emergency room visits	1,430,193	1,413,831	16,362	1.2 %
Surgeries	316,298	314,564	1,734	0.6 %
Outpatient revenue percent	51.6%	50.0%	160 bps	n/a
Inpatient revenue percent	48.4%	50.0%	(160) bps	n/a
Total Hospitals				
Occupancy	42.8%	43.9%	(110) bps	n/a
Patient days	1,424,500	1,350,697	73,803	5.5 %
Admissions	338,637	323,917	14,720	4.5 %
Adjusted admissions †	635,934	586,060	49,874	8.5 %
Emergency room visits	1,562,028	1,413,831	148,197	10.5 %
Surgeries	342,421	314,564	27,857	8.9 %
Outpatient revenue percent	51.9%	50.0%	190 bps	n/a
Inpatient revenue percent	48.1%	50.0%	(190) bps	n/a

\* Includes acquired hospitals to the extent we operated them for comparable periods

\*\* basis points

† Admissions adjusted for outpatient volume

Net revenue during the 2011 Calendar Year was approximately \$5,804.5 million as compared to \$5,092.2 million during the 2010 Calendar Year. This change represented an increase of \$712.3 million, or 14.0%. Our same 2011 hospitals provided \$243.3 million, or 34.2%, of the increase in net revenue as a result of: (i) increased outpatient and surgical volume from, among other things, market service development activities; (ii) an increase in emergency room visits; and (iii) improvements in reimbursement rates. These items were partially offset by a decrease in hospital admissions, which was primarily due to a reduction in admissions of uninsured patients and certain weather-related disruptions. The remaining 2011 net revenue increase of \$469.0 million was due to our acquisitions of: (i) Shands in July 2010; (ii) Wuesthoff in October 2010; (iii) Tri-Lakes in May 2011; and (iv) the Mercy Hospitals in September 2011.

Net revenue per adjusted admission increased approximately 5.0% during the 2011 Calendar Year as compared to the 2010 Calendar Year. The factors contributing to such change included higher patient acuity, increased surgical volume and the favorable effects of renegotiated agreements with certain commercial health insurance providers.

Our provision for doubtful accounts during the 2011 Calendar Year increased 10 basis points to 12.4% of net revenue as compared to 12.3% of net revenue during the 2010 Calendar Year. This change was primarily due to amounts considered to be patient responsibility (e.g., deductibles, co-payments, other amounts not covered by insurance, etc.).

Our consistently applied accounting policy is that accounts written off as charity and indigent care are not recognized in net revenue and, accordingly, such amounts have no impact on our provision for doubtful accounts. However, as a measure of our fiscal performance, we routinely aggregate amounts pertaining to our (i) provision for doubtful accounts, (ii) uninsured self-pay patient discounts and (iii) foregone/unrecognized revenue for charity and indigent care and divide the resulting total by the sum of our (i) net revenue, (ii) uninsured self-pay patient discounts and (iii) foregone/unrecognized revenue for charity and indigent care. We believe that this fiscal measure, which we refer to as our Uncompensated Patient Care Percentage, provides us with key information regarding the aggregate level of patient care for which we do not receive remuneration. During the 2011 Calendar Year and the 2010 Calendar Year, our Uncompensated Patient Care Percentage was 25.6% and 25.2%, respectively. This 40 basis point increase during the 2011 Calendar Year primarily reflects greater uninsured self-pay patient revenue discounts, partially offset by a decline in self-pay patients in the mix of patients that we serve.

Salaries and benefits as a percent of net revenue increased to 39.7% during the 2011 Calendar Year from 39.6% during the 2010 Calendar Year. During the 2011 Calendar Year, increased costs for routine salary and wage increases and disproportionately higher salaries and benefits at our recent acquisitions (including restructuring activities at the Mercy Hospitals) were mostly offset by cost containment measures such as flexible staffing and new hire limitations.

Supplies as a percent of net revenue decreased from 13.8% during the 2010 Calendar Year to 13.4% during the 2011 Calendar Year. This decrease was primarily due to improved pricing and greater discounts from our group purchasing agreement and a favorable change in our surgical volume mix during the 2011 Calendar Year.

Rent expense as a percent of net revenue increased during the 2011 Calendar Year as compared to the 2010 Calendar Year while depreciation and amortization expense as a percent of net revenue declined. In recent years, we have entered into more operating lease arrangements. As our use of operating leases has increased, depreciation and amortization expense has declined and rent expense has increased. Additionally, certain of our hospital buildings reached the end of their depreciable lives during 2010, which further reduced depreciation and amortization expense in 2011.

Other operating expenses as a percent of net revenue increased from 17.5% during the 2010 Calendar Year to 18.4% during the 2011 Calendar Year. This increase was primarily due to the costs associated with: (i) the acquisition of the Mercy Hospitals; (ii) restructuring activities at the Mercy Hospitals; and (iii) certain government investigations. See Notes 4 and 13 to the Consolidated Financial Statements in Item 8 for information regarding our recent acquisitions and our ongoing government investigations, respectively. Also contributing to the 2011 increase in other operating expenses were: (i) higher state-mandated provider taxes and increased repairs and maintenance costs during the 2011 Calendar Year; (ii) certain services at our hospitals that have been recently outsourced and/or contracted to third parties; and (iii) disproportionately higher costs at our recent acquisitions.

During the 2011 Calendar Year, we recognized a first time benefit of approximately \$40.0 million under the meaningful use measurement standard of the HCIT Programs.

Interest expense increased from approximately \$211.7 million during the 2010 Calendar Year to \$222.7 million during the 2011 Calendar Year. Such increase was primarily due to non-cash interest expense of \$16.4 million attributable to our interest rate swap contract (i.e., accumulated other comprehensive loss amortization and net fair value adjustment expense) that was recognized after the 2011 Debt Restructuring on November 18, 2011. This increase was partially offset by a lower overall effective interest rate on our former \$2.75 billion seven-year term loan because less of the outstanding balance thereunder was covered by our interest rate swap contract. We also maintained a lower average outstanding principal balance on such term loan during the 2011 Calendar Year as compared to the 2010 Calendar Year and recorded a greater amount of capitalized interest during the 2011 Calendar Year. See "Liquidity, Capital Resources and Capital Expenditures" below and Note 2 to the Consolidated Financial Statements in Item 8 for information regarding our long-term debt arrangements and interest rate swap contract.

As a result of the 2011 Debt Restructuring, we wrote-off approximately \$24.0 million of deferred debt issuance costs and incurred \$0.6 million of related costs. See Note 2 to the Consolidated Financial Statements in Item 8 for information regarding our long-term debt and the 2011 Debt Restructuring.

Our effective income tax rates were approximately 34.0% and 35.2% during the 2011 Calendar Year and the 2010 Calendar Year, respectively. Net income attributable to noncontrolling interests, which is not tax-effected in our consolidated financial statements, reduced our effective income tax rates by approximately 290 basis points and 230 basis points during the 2011 Calendar Year and the 2010 Calendar Year, respectively. Also, see Note 6 to the Consolidated Financial Statements in Item 8 for further information regarding our effective income tax rates.

### 2010 Calendar Year Compared to the 2009 Calendar Year

The tables below summarize our operating results for the 2010 Calendar Year and the year ended December 31, 2009, which we refer to as the 2009 Calendar Year. Hospitals that were owned/leased and operated by us for one year or more as of December 31, 2010 are referred to as same 2010 hospitals. For all year-over-year comparative discussions herein, the operating results of our same 2010 hospitals are only considered to the extent that there was a similar period of operation in both years.

	Years Ended December 31,			
	2010		2009	
	Amount (in thousands)	Percent of Net Revenue	Amount (in thousands)	Percent of Net Revenue
Net revenue	\$ 5,092,166	100.0%	\$ 4,536,106	100.0%
Salaries and benefits	2,016,967	39.6	1,779,440	39.2
Supplies	703,426	13.8	637,663	14.1
Provision for doubtful accounts	624,753	12.3	553,639	12.2
Rent expense	122,983	2.4	100,990	2.2
Other operating expenses	892,465	17.5	788,051	17.4
Depreciation and amortization	241,873	4.8	234,883	5.2
Interest expense	211,673	4.2	217,938	4.8
Gains on early extinguishment of debt, net	-	-	(16,202)	(0.4)
Write-offs of deferred debt issuance costs	-	-	444	-
Other	(8,797)	(0.2)	(4,980)	(0.1)
	<u>4,805,343</u>	<u>94.4</u>	<u>4,291,866</u>	<u>94.6</u>
Income from continuing operations before income taxes	286,823	5.6	244,240	5.4
Provision for income taxes	(101,049)	(2.0)	(82,937)	(1.8)
Income from continuing operations	<u>\$ 185,774</u>	<u>3.6%</u>	<u>\$ 161,303</u>	<u>3.6%</u>

	Years Ended December 31,		Change	Percent Change
	2010	2009		
<b>Same 2010 Hospitals*</b>				
Occupancy	43.6%	45.3%	(170) bps**	n/a
Patient days	1,243,275	1,281,093	(37,818)	(3.0)%
Admissions	301,127	306,184	(5,057)	(1.7)%
Adjusted admissions †	542,628	533,101	9,527	1.8 %
Emergency room visits	1,312,705	1,352,044	(39,339)	(2.9)%
Surgeries	294,999	281,285	13,714	4.9 %
Outpatient revenue percent	50.1%	48.5%	160 bps	n/a
Inpatient revenue percent	49.9%	51.5%	(160) bps	n/a
<b>Total Hospitals</b>				
Occupancy	43.9%	45.3%	(140) bps	n/a
Patient days	1,350,697	1,281,093	69,604	5.4 %
Admissions	323,917	306,184	17,733	5.8 %
Adjusted admissions †	586,060	533,101	52,959	9.9 %
Emergency room visits	1,413,831	1,352,044	61,787	4.6 %
Surgeries	314,564	281,285	33,279	11.8 %
Outpatient revenue percent	50.0%	48.5%	150 bps	n/a
Inpatient revenue percent	50.0%	51.5%	(150) bps	n/a

\* Includes acquired hospitals to the extent we operated them for comparable periods

\*\* basis points

† Admissions adjusted for outpatient volume

Net revenue during the 2010 Calendar Year was approximately \$5,092.2 million as compared to \$4,536.1 million during the 2009 Calendar Year. This change represented an increase of \$556.1 million, or 12.3%. Our same 2010 hospitals provided \$182.7 million, or 32.9%, of the increase in net revenue as a result of increased surgical volume attributable to physician recruitment and market service development, as well as improvements in reimbursement rates. These items were partially offset by decreases in hospital admissions and emergency room visits, as well as unfavorable movement in our payor mix. Among other things, hospital admissions and emergency room visits declined in 2010 due to (i) fewer births at our hospitals and (ii) a less severe 2010 flu season as compared to 2009 when there was an outbreak of H1N1 influenza ("swine flu") in the United States. The remaining 2010 net revenue increase of \$373.4 million was due to our acquisitions of: (i) the 492-bed Sparks Health System ("Sparks") in Fort Smith, Arkansas in December 2009; (ii) Shands in July 2010; and (iii) Wuesthoff in October 2010.

Net revenue per adjusted admission increased approximately 2.1% during the 2010 Calendar Year as compared to the 2009 Calendar Year. The factors contributing to such change included increased patient acuity and the favorable effects of renegotiated agreements with certain commercial health insurance providers, partially offset by the unfavorable movement in our payor mix during the 2010 Calendar Year.

Our provision for doubtful accounts during the 2010 Calendar Year increased 10 basis points to 12.3% of net revenue as compared to 12.2% of net revenue during the 2009 Calendar Year. This change was primarily due to an increase in uninsured patients in the mix of patients that we serve (approximately 7.1% and 7.0% of total hospital admissions during the 2010 Calendar Year and the 2009 Calendar Year, respectively), which can be attributed, in part, to the prolonged downturn in the economy and correspondingly higher levels of unemployment. During the 2010 Calendar Year and the 2009 Calendar Year, our Uncompensated Patient Care Percentage, which is described above under the heading "2011 Calendar Year Compared to the 2010 Calendar Year," was 25.2% and 24.3%, respectively. This 90 basis point increase during the 2010 Calendar Year primarily reflects greater uninsured self-pay patient revenue discounts and unfavorable movement in our payor mix.

Salaries and benefits as a percent of net revenue increased to 39.6% during the 2010 Calendar Year from 39.2% during the 2009 Calendar Year. This increase was primarily due to disproportionately higher salaries and benefits at our 2010 and 2009 acquisitions.

Supplies as a percent of net revenue decreased from 14.1% during the 2009 Calendar Year to 13.8% during the 2010 Calendar Year. This decrease was primarily due to improved pricing and greater discounts from our group purchasing agreement and a favorable change in our surgical volume mix during the 2010 Calendar Year.

Rent expense as a percent of net revenue increased during the 2010 Calendar Year as compared to the 2009 Calendar Year while depreciation and amortization expense as a percent of net revenue declined. See above under the heading "2011 Calendar Year Compared to the 2010 Calendar Year" for the factors contributing to these changes.

Other operating expenses as a percent of net revenue increased from 17.4% during the 2009 Calendar Year to 17.5% during the 2010 Calendar Year. This change was primarily due to an increase in attorneys' fees and disproportionately higher operating expenses at our recent acquisitions.

Interest expense decreased from approximately \$217.9 million during the 2009 Calendar Year to \$211.7 million during the 2010 Calendar Year. Such decrease was primarily due to a lower overall effective interest rate on our former \$2.75 billion seven-year term loan because less of the outstanding balance thereunder was covered by our interest rate swap contract. We also maintained lower average outstanding principal balances on such term loan and our convertible debt securities during the 2010 Calendar Year as compared to the 2009 Calendar Year. These reductions in interest expense were partially offset by a lesser amount of capitalized interest during the 2010 Calendar Year. See Note 2 to the Consolidated Financial Statements in Item 8 for information regarding our long-term debt arrangements.

During the 2009 Calendar Year, we repurchased certain of our convertible debt securities, which yielded a net gain on the early extinguishment of debt of approximately \$16.2 million. See Note 2(c) to the Consolidated Financial Statements in Item 8 for information regarding our convertible debt repurchases.

Our effective income tax rates were approximately 35.2% and 34.0% during the 2010 Calendar Year and the 2009 Calendar Year, respectively. Net income attributable to noncontrolling interests, which is not tax-effected in our consolidated financial statements, reduced our effective income tax rates by approximately 230 basis points and 380 basis points during the 2010 Calendar Year and the 2009 Calendar Year, respectively. Also, see Note 6 to the Consolidated Financial Statements in Item 8 for further information regarding our effective income tax rates.

## Liquidity, Capital Resources and Capital Expenditures

### Liquidity

Our cash flows from continuing operating activities provide the primary source of cash for our ongoing business needs. Additionally, at December 31, 2011 approximately \$81.7 million of our available-for-sale securities and \$400.3 million of borrowing capacity under our new \$500.0 million long-term revolving credit facility were available for, among other things, general business purposes and acquisitions. As discussed at Note 15 to the Consolidated Financial Statements in Item 8, we plan to fund the pending acquisition of an 80% equity interest in each of five Oklahoma-based general acute care hospitals and certain related health care operations with available cash balances and proceeds from sales of available-for-sale securities. We believe that our various sources of cash are adequate to meet our foreseeable operating, capital expenditure, business acquisition and debt service needs.

Below is a summary of our recent cash flow activity (in thousands).

	Years Ended December 31,		
	2011	2010	2009
Sources (uses) of cash and cash equivalents:			
Operating activities	\$ 544,022	\$ 434,691	\$ 434,576
Investing activities	(976,011)	(393,653)	(357,253)
Financing activities	401,223	(49,483)	(127,451)
Discontinued operations	(6,903)	4,239	12,532
Net decrease in cash and cash equivalents	<u>\$ (37,669)</u>	<u>\$ (4,206)</u>	<u>\$ (37,596)</u>

### 2011 Calendar Year Cash Flows Compared to the 2010 Calendar Year Cash Flows

#### Operating Activities

Our cash flows from continuing operating activities increased approximately \$109.3 million, or 25.2%, during the 2011 Calendar Year as compared to the 2010 Calendar Year. This increase primarily related to: (i) improved profitability, including our receipt of \$38.3 million under the meaningful use measurement standard of the HCIT Programs; (ii) reductions in both our interest payments and our net federal and state income tax payments during the 2011 Calendar Year when compared to the 2010 Calendar Year; and (iii) increases in our accounts payable, accrued expenses and other liabilities, which were primarily due to our recent acquisitions. Partially offsetting the abovementioned favorable developments during the 2011 Calendar Year was an increase in accounts receivable at the Mercy Hospitals, which we acquired on September 30, 2011.

Prospectively, we believe that our cash flows from continuing operating activities will be adversely impacted through the middle of 2012 by delayed cash collections on accounts receivable at the Mercy Hospitals; however, our new \$500.0 million long-term revolving credit facility, which is described under "Capital Resources" below and Note 2 to the Consolidated Financial Statements in Item 8, is available to provide post-acquisition working capital, if necessary, while we await approvals to bill and collect under the Medicare and Medicaid provider numbers that we assumed (see further discussion below under "Days Sales Outstanding"). We also believe that the professional and other costs of our ongoing government investigations, while difficult to predict, will continue and will vary throughout the duration of such investigations. Those costs will be paid with our cash flows from continuing operating activities. See Note 13 to the Consolidated Financial Statements in Item 8 for information regarding such government investigations. Although subject to change due to a variety of factors beyond our control, we project that during the year ending December 31, 2012 (i) we will pay \$87.0 million to the counterparties of our interest rate swap contract, which is discussed at Note 2(a) to the Consolidated Financial Statements in Item 8, and (ii) we will receive additional reimbursement under the meaningful use measurement standard of the HCIT Programs ranging from \$90 million to \$120 million.

#### Investing Activities

Cash used in investing activities during the 2011 Calendar Year included: (i) approximately \$302.0 million of additions to property, plant and equipment, consisting primarily of new medical equipment (including \$20.7 million to purchase da Vinci® robotic surgical systems), information technology hardware and software upgrades, renovation and expansion projects at certain of our facilities and replacement hospital construction (including a hospital that opened in May 2011 to replace Madison County Medical Center in Canton, Mississippi and a new 250-

bed hospital that is currently under construction and will ultimately replace our south campus facility at Poplar Bluff Regional Medical Center in Poplar Bluff, Missouri); (ii) \$520.0 million to acquire the six Mercy Hospitals; (iii) \$38.8 million to acquire a 95% equity interest in a Mississippi-based hospital (Tri-Lakes); (iv) \$23.3 million to acquire ten ancillary health care businesses; and (v) a \$35.3 million increase in our restricted funds. See Note 4 to the Consolidated Financial Statements in Item 8 for information regarding our recent acquisitions. Excluding the available-for-sale securities in restricted funds, we had a net cash outlay of \$64.2 million from buying and selling such securities during the 2011 Calendar Year. These 2011 cash outlays were partially offset by (i) \$4.9 million of proceeds from the sales of the remaining real property at Gulf Coast Medical Center, our closed hospital facility in Biloxi, Mississippi, and certain assets at Fishermen's Hospital in Marathon, Florida and (ii) \$2.8 million of proceeds from sales of assets and insurance recoveries.

Cash used in investing activities during the 2010 Calendar Year included: (i) approximately \$209.1 million of additions to property, plant and equipment, consisting primarily of new medical equipment, information technology hardware and software upgrades, renovation and expansion projects at certain of our facilities and construction of a hospital to replace Madison County Medical Center; (ii) \$152.0 million for the acquisition of two Florida-based hospitals (Wuesthoff); (iii) \$21.5 million to acquire a 60% equity interest in each of three Florida-based hospitals (Shands); (iv) \$18.0 million to acquire six ancillary health care businesses; and (v) a \$5.8 million increase in our restricted funds. Excluding the available-for-sale securities in restricted funds, we had a net cash outlay of \$16.8 million from buying and selling such securities during the 2010 Calendar Year. These 2010 cash outlays were partially offset by (i) \$26.4 million of proceeds from the sale of Riley Hospital in Meridian, Mississippi, which is discussed at Note 10 to the Consolidated Financial Statements in Item 8, and (ii) \$3.2 million of proceeds from sales of assets and insurance recoveries.

#### *Financing Activities*

During the 2011 Calendar Year, we received approximately \$389.2 million of cash proceeds from a syndicate of banks, including \$29.2 million under a then existing revolving credit facility to: (i) finance the acquisition of seven Tennessee-based general acute care hospitals and other ancillary health care operations from Catholic Health Partners and its subsidiary Mercy Health Partners, Inc.; (ii) pay certain closing costs of a credit agreement, which is described at Note 2(d) to the Consolidated Financial Statements in Item 8; and (iii) provide start-up working capital to certain of our subsidiaries that are affiliated with the newly acquired hospitals. In connection with the 2011 Debt Restructuring, we received \$2,967.8 million of proceeds from new debt arrangements, which was primarily used to repay all of the principal and accrued interest outstanding under certain of our then existing debt agreements. As a result of the 2011 Debt Restructuring and normal recurring activity, our aggregate principal payments on long-term debt and capital lease obligations were \$2,869.4 million during the 2011 Calendar Year. We also paid \$75.1 million for debt issuance costs related to our new credit agreements and \$28.3 million to noncontrolling shareholders primarily for recurring distributions. During the 2011 Calendar Year our cash provided by continuing financing activities also included (i) \$14.1 million of cash proceeds from exercises of stock options and (ii) \$3.0 million of excess income tax benefits from our stock-based compensation arrangements. See Notes 2 and 3 to the Consolidated Financial Statements in Item 8 for information regarding our long-term debt arrangements and capital lease obligations, respectively.

During the 2010 Calendar Year, we made principal payments on long-term debt and capital lease obligations of approximately \$40.1 million. We also paid \$20.6 million to noncontrolling shareholders primarily for recurring distributions. Partially offsetting these cash outlays were (i) \$7.5 million of cash proceeds from exercises of stock options and (ii) \$2.5 million that we received from noncontrolling shareholders to acquire minority equity interests in one of our joint ventures.

#### *Discontinued Operations*

Cash used by our discontinued operations during the 2011 Calendar Year was approximately \$6.9 million, including \$12.4 million of purchase price allocated from the abovementioned Mercy Health Partners, Inc. acquisition. The cash provided by our discontinued operations during the 2010 Calendar Year was \$4.2 million. We do not believe that the exclusion of such amounts from our consolidated cash flows in future periods will have a material effect on our liquidity or financial position. See Note 10 to the Consolidated Financial Statements in Item 8 for information regarding our discontinued operations.

## ***2010 Calendar Year Cash Flows Compared to the 2009 Calendar Year Cash Flows***

### ***Operating Activities***

Our cash flows from continuing operating activities were approximately the same amount during the 2010 Calendar Year and the 2009 Calendar Year. However, we experienced increased cash flows during the 2010 Calendar Year from (i) improved operating profitability and (ii) increases in our liabilities during the 2010 Calendar Year that were primarily due to the timing of vendor payments. Offsetting these items were (i) income taxes (i.e., net federal and state income tax payments of \$56.7 million and \$1.7 million during the 2010 Calendar Year and the 2009 Calendar Year, respectively) and (ii) an increase in accounts receivable from the hospital acquisitions that we completed during 2010.

### ***Investing Activities***

Cash used in investing activities during the 2010 Calendar Year included: (i) approximately \$209.1 million of additions to property, plant and equipment, consisting primarily of new medical equipment, information technology hardware and software upgrades, renovation and expansion projects at certain of our facilities and construction of a hospital to replace Madison County Medical Center in Canton, Mississippi; (ii) \$152.0 million for the acquisition of two Florida-based hospitals (Wuesthoff); (iii) \$21.5 million to acquire a 60% equity interest in each of three Florida-based hospitals (Shands); (iv) \$18.0 million to acquire six ancillary health care businesses; and (v) a \$5.8 million increase in our restricted funds. See Note 4 to the Consolidated Financial Statements in Item 8 for information regarding our recent acquisitions. Excluding the available-for-sale securities in restricted funds, we had a net cash outlay of \$16.8 million from buying and selling such securities during the 2010 Calendar Year. These 2010 cash outlays were partially offset by (i) \$26.4 million of proceeds from the sale of Riley Hospital in Meridian, Mississippi, which is discussed at Note 10 to the Consolidated Financial Statements in Item 8, and (ii) \$3.2 million of proceeds from sales of assets and insurance recoveries.

Cash used in investing activities during the 2009 Calendar Year included (i) approximately \$198.9 million of additions to property, plant and equipment, consisting primarily of renovation and expansion projects at certain of our facilities, and (ii) \$138.2 million for the acquisition of a health system in Fort Smith, Arkansas (Sparks). Excluding the available-for-sale securities in restricted funds, we had a net cash outlay of \$36.5 million from buying and selling such securities during the 2009 Calendar Year. These 2009 cash outlays were partially offset by a decrease in restricted funds of \$11.6 million and \$5.4 million of proceeds from sales of assets.

### ***Financing Activities***

During the 2010 Calendar Year, we made principal payments on long-term debt and capital lease obligations of approximately \$40.1 million. We also paid \$20.6 million to noncontrolling shareholders primarily for recurring distributions. Partially offsetting these cash outlays were (i) \$7.5 million of cash proceeds from exercises of stock options and (ii) \$2.5 million that we received from noncontrolling shareholders to acquire minority equity interests in one of our joint ventures. See Notes 2 and 3 to the Consolidated Financial Statements in Item 8 for information regarding our long-term debt arrangements and capital lease obligations, respectively.

During the 2009 Calendar Year, we borrowed and repaid \$38.0 million under our then existing revolving credit facility to fund the acquisition of Sparks. Furthermore, we made principal payments on our other long-term debt and capital lease obligations of approximately \$89.1 million, including mandatory and other prepayments of \$43.4 million on certain then existing bank term loan indebtedness. During the 2009 Calendar Year, we also paid (i) \$67.7 million to repurchase certain of our 3.75% Convertible Senior Subordinated Notes due 2028 in the open market and (ii) \$35.4 million to noncontrolling shareholders, including distributions of \$19.6 million from our joint venture in North Carolina and South Carolina and \$6.2 million in connection with the restructuring of such joint venture. These 2009 cash outlays were partially offset by \$54.8 million that we received from noncontrolling shareholders to acquire minority equity interests in our joint ventures and cash proceeds from exercises of stock options of \$9.7 million. See Note 4 to the Consolidated Financial Statements in Item 8 for information regarding our joint venture activity.

### ***Discontinued Operations***

Cash provided by our discontinued operations during the 2010 Calendar Year and the 2009 Calendar Year was approximately \$4.2 million and \$12.5 million, respectively. We do not believe that the exclusion of such amounts from our consolidated cash flows in future periods will have a material effect on our liquidity or financial position. See Note 10 to the Consolidated Financial Statements in Item 8 for information regarding our discontinued operations.

## **Days Sales Outstanding**

To calculate days sales outstanding, or DSO, we initially divide quarterly net revenue by the number of days in the quarter. The result is divided into the net patient accounts receivable balance at the end of the quarter to obtain our DSO. We believe that this statistic is an important measure of collections on our accounts receivable, as well as our liquidity. Our DSO was 51 days at December 31, 2011, which compares to 52 days at September 30, 2011 and 49 days at December 31, 2010.

At December 31, 2011, we were in the process of obtaining the necessary approvals for our Medicare and Medicaid provider numbers for the Mercy Hospitals and their related ancillary health care operations, which we acquired on September 30, 2011. While the necessary approvals are pending, we are unable to bill for the services that we provided at those facilities, which caused our accounts receivable to grow and correspondingly increased our DSO by approximately two days at December 31, 2011. See Note 4 to the Consolidated Financial Statements in Item 8 for information regarding our acquisition of the Mercy Hospitals. Our DSO at December 31, 2011 was also adversely impacted by certain ongoing system and billing conversions that affect our accounts receivable software applications.

## **Income Taxes**

Other than certain state net operating loss carryforwards, we believe that it is more likely than not that reversals of existing taxable temporary differences, future taxable income and carrybacks will allow us to realize the deferred tax assets that are recognized in our consolidated balance sheets.

## **Effect of Legislative and Regulatory Action on Liquidity**

The Medicare and Medicaid reimbursement programs are subject to change as a result of legislative and regulatory actions. Within the statutory framework of those programs, numerous areas are subject to administrative rulings, interpretations and discretion that could affect payments made to us. In the future, federal and/or state governments might (i) reduce the funds available under those programs to close budget gaps or reduce deficit spending or (ii) require more stringent utilization and quality reviews of hospital facilities, either of which could have a material adverse effect on our future revenue and liquidity. Additionally, the implementation of the Health Care Reform Act, which dramatically affects the financing and delivery of health care services in the United States, and/or the continued prevalence of managed care health plans could have an adverse effect on our future revenue and liquidity. For further discussion of the Health Care Reform Act and its possible impact on our business and results of operations, see "Business – Sources of Revenue" in Item 1 of Part I and "Risk Factors" in Item 1A of Part I.

## **Capital Resources**

**Senior Secured Credit Facilities.** As more fully described at Note 2 to the Consolidated Financial Statements in Item 8, we completed the 2011 Debt Restructuring on November 18, 2011, which included, among other things, new variable rate senior secured credit facilities with a syndicate of banks (the "New Credit Facilities"). The New Credit Facilities consist of: (i) a \$500.0 million five-year revolving credit facility (the "New Revolving Credit Agreement"); (ii) a \$725.0 million five-year term loan (the "New Term Loan A"); and (iii) a \$1.4 billion seven-year term loan (the "New Term Loan B"). We used the net proceeds from the term loans under the New Credit Facilities, together with the net proceeds from the sale of our 7.375% Senior Notes due 2020, to repay all of the principal and accrued interest outstanding under certain of our then existing debt agreements.

We can elect whether interest on borrowings under the New Credit Facilities is calculated using LIBOR or the Prime Rate (as defined in the loan agreement) as its base rate; however, the base rate for the New Term Loan B is subject to a floor of 1.0% when the LIBOR option is selected. The effective interest rate, which fluctuates with changes in the underlying base rates, includes a spread above the base rate that we select. The amount of the interest rate spread is predicated on, among other things, our Consolidated Leverage Ratio (as defined in the loan agreement). We can elect differing interest rates for each of the debt instruments that comprise the New Credit Facilities. Interest is payable in arrears at the end of a calendar quarter or on the date that the selected interest duration period ends.

Beginning on March 31, 2012, the New Term Loan A will be repaid in equal quarterly installments in an aggregate annual amount equal to 7.5% of the principal amount thereof in each of the first two years of such facility, 10.0% in the third year, 15.0% in the fourth year and 60.0% in the fifth year. The New Term Loan B requires quarterly principal payments of \$3.5 million, beginning on March 31, 2012, and a balloon payment for the remaining outstanding balance at the end of the facility's seventh year. We have the right to prepay amounts outstanding under the New Credit Facilities at any time without penalty, other than a prepayment of the New Term Loan B, which is subject to a prepayment premium during the first year of the loan agreement. At December 31, 2011, the effective interest rates on the New Term Loan A and the New Term Loan B were 3.2% and 4.5%, respectively. Those rates remained unchanged as of February 17, 2012.

Throughout the New Revolving Credit Agreement's five-year term, we are obligated to pay commitment fees based on the amounts available for borrowing. The New Revolving Credit Agreement provides that we can borrow, on a revolving basis, up to an aggregate of \$500.0 million, as adjusted for outstanding standby letters of credit of up to \$75.0 million. We did not borrow under the New Revolving Credit Agreement during the period from November 18, 2011 to December 31, 2011. Although there were no amounts outstanding under the New Revolving Credit Agreement on February 17, 2012, standby letters of credit in favor of third parties of approximately \$51.9 million reduced the amount available for borrowing thereunder to \$448.1 million on such date. Our effective interest rate on the variable rate New Revolving Credit Agreement was approximately 3.2% on February 17, 2012.

The New Credit Facilities are generally subject to mandatory prepayment in amounts equal to: (i) 100% of the net cash proceeds received from certain asset sales, including insurance recoveries and condemnation events, subject to reinvestment provisions and the ratable offer requirements of other pari passu secured debt; (ii) 100% of the net cash proceeds from our issuance of certain new debt; and (iii) 50% of our Excess Cash Flow (as defined in the loan agreement) with step-downs of such percentage based on our Consolidated Leverage Ratio.

We intend to fund the required principal payments under the term loans of the New Credit Facilities and the related interest with available cash balances, cash provided by operating activities, proceeds from sales of available-for-sale securities and, if necessary, borrowings under the New Revolving Credit Agreement.

***Demand Promissory Note.*** We maintain a \$10.0 million secured demand promissory note in favor of a bank for use as a working capital line of credit in conjunction with our cash management program. Pursuant to the terms and conditions of the demand promissory note, we may borrow, on a revolving basis, up to the principal face amount of the note. All principal and accrued interest under the demand promissory note will be immediately due and payable upon the bank's written demand. We did not borrow under this credit facility during the 2011 Calendar Year. The demand promissory note's effective interest rate on February 17, 2012 was approximately 2.5%; however, there were no amounts outstanding thereunder on such date.

***7.375% Senior Notes due 2020.*** As more fully described at Note 2(b) to the Consolidated Financial Statements in Item 8, on November 18, 2011 we completed a private placement of \$875.0 million in aggregate principal amount of 7.375% Senior Notes due 2020 (the "2020 Senior Notes"). We used the net proceeds from this debt offering, together with the net proceeds from the term loans under the New Credit Facilities, to repay all of the principal and accrued interest outstanding under certain of our then existing debt agreements. The 2020 Senior Notes are senior unsecured debt obligations that bear interest at the rate of 7.375% per annum, payable semi-annually in arrears on January 15 and July 15 of each year, beginning on July 15, 2012. The 2020 Senior Notes mature on January 15, 2020 at which time the entire \$875.0 million of principal is due and payable. At any time on or after January 15, 2016, the 2020 Senior Notes are redeemable at our option, in whole or in part, at the redemption prices set forth in the related indenture, plus accrued and unpaid interest. Prior to January 15, 2016, we may redeem the 2020 Senior Notes, in whole or in part, at a redemption price equal to 100% of the principal amount of the notes being redeemed, plus a "make-whole" premium and accrued and unpaid interest. Prior to January 15, 2015, we may also redeem up to 35% of the original principal amount of the 2020 Senior Notes with the proceeds from certain equity offerings at a redemption price of 107.375% of the principal amount of the notes being redeemed, plus accrued and unpaid interest.

We intend to fund the required semi-annual interest payments under the 2020 Senior Notes with available cash balances, cash provided by operating activities, proceeds from sales of available-for-sale securities and, if necessary, borrowings under the New Revolving Credit Agreement.

## **Debt Covenants**

The New Credit Facilities and the indentures governing our convertible debt securities, the 2020 Senior Notes and our 6.125% Senior Notes due 2016 contain covenants that, among other things, require us to maintain compliance with certain financial ratios. At December 31, 2011, we were in compliance with all of the covenants contained in those debt agreements. Although there can be no assurances, we believe that we will continue to be in compliance with all of our debt covenants. Should we fail to comply with one or more of our debt covenants in the future and are unable to remedy the matter, an event of default may result. In that circumstance, we would seek a waiver from our lenders or renegotiate the related debt agreement; however, such renegotiations could, among other things, subject us to higher interest and financing costs on our debt obligations and our credit ratings could be adversely affected.

## **Dividends**

The New Credit Facilities and the indentures for certain of our other debt agreements restrict our ability to pay cash dividends.

## **Standby Letters of Credit**

As of February 17, 2012, we maintained approximately \$54.1 million of standby letters of credit in favor of third parties with various expiration dates through February 21, 2013. Should any or all of these letters of credit be drawn upon, we intend to satisfy such obligations with available cash balances, cash provided by operating activities, proceeds from sales of available-for-sale securities and, if necessary, borrowings under the New Revolving Credit Agreement.

## **Interest Rate Swap Contract**

As required by a former credit facility, we entered into a seven-year receive variable/pay fixed interest rate swap contract during February 2007. As part of the 2011 Debt Restructuring, such credit facility was terminated but the interest rate swap contract was not. Although we are exposed to financial risk in the event of nonperformance by one or more of the counterparties to the contract, we do not anticipate nonperformance because our interest rate swap contract is in a liability position and would require us to make settlement payments to the counterparties in the event of a contract termination. The interest rate swap contract provides for us to pay interest at a fixed rate of 6.7445% on the contract's notional amount, which was originally expected to reasonably approximate the declining principal balance of a term loan under the former credit facility. At December 31, 2011, the notional amount of the interest rate swap contract was approximately \$2,027.4 million. The estimated fair value of our liability for the interest rate swap contract on such date was \$162.3 million and we project that \$87.0 million will be payable to the counterparties during the year ending December 31, 2012. However, our aggregate payments through the contract's expiration in February 2014, as well as the specific timing thereof, are subject to change based on, among other things, future LIBOR rates. See Note 5 to the Consolidated Financial Statements in Item 8 for information regarding the estimated fair value of our interest rate swap contract.

Net interest payable or receivable is settled between us and the counterparties at the end of each calendar quarter. We intend to fund any net interest payable to the counterparties with available cash balances, cash provided by operating activities, proceeds from sales of available-for-sale securities and, if necessary, borrowings under the New Revolving Credit Agreement.

## **Capital Expenditures and Other**

We believe that capital expenditures for property, plant and equipment will range from 4.5% to 5.5% of our net revenue (before the provision for doubtful accounts) for the year ending December 31, 2012, which is within the capital expenditure limitations of the New Credit Facilities. As of December 31, 2011, we had started: (i) construction of a 250-bed general acute care hospital to ultimately replace the south campus facility at Poplar Bluff Regional Medical Center in Poplar Bluff, Missouri; (ii) several hospital renovation and expansion projects; and (iii) various information technology hardware and software upgrades. Additionally, we estimate that the remaining cost to build and equip a replacement hospital for Walton Regional Medical Center in Monroe, Georgia will range from \$20 million to \$25 million. We are currently obligated to complete construction of this replacement hospital no later than December 31, 2012. We do not believe that any of our construction, renovation and/or expansion projects are individually significant or that they represent, in the aggregate, a material commitment of our resources.

Part of our strategic business plan calls for us to acquire hospitals and other ancillary health care businesses in non-urban communities that are aligned with our business model, available at a reasonable price and otherwise meet our strict acquisition criteria. We fund acquisitions, replacement hospital construction and other recurring capital expenditures with available cash balances, cash provided by operating activities, proceeds from sales of available-for-sale securities, amounts available under revolving credit agreements and proceeds from long-term debt issuances, or a combination thereof. Specifically, we plan to fund the acquisition of an 80% equity interest in each of five Oklahoma-based general acute care hospitals and certain related health care operations with available cash balances and proceeds from sales of available-for-sale securities. This pending acquisition, which we expect to close during the quarter ending June 30, 2012, is discussed at Note 15 to the Consolidated Financial Statements in Item 8.

## Divestitures of Idle Property and Other

We intend to sell (i) the Woman's Center at Dallas Regional Medical Center, which was a specialty women's hospital in Mesquite, Texas that we closed on June 1, 2008, and (ii) the former Riverside hospital campus that we acquired from Mercy Health Partners, Inc. on September 30, 2011. We are also exploring various alternatives for St. Mary's Medical Center of Scott County wherein the hospital's lease agreement expires in May 2012 and will not be renewed. However, the timing of such divestitures has not yet been determined. We intend to use the proceeds from any transactions involving the abovementioned facilities for general business purposes. See Note 10 to the Consolidated Financial Statements in Item 8 for information about the three facilities that we intend to divest.

## Contractual Obligations and Off-Balance Sheet Arrangements

Except as set forth in the table below, we do not have any off-balance sheet arrangements.

As of December 31, 2011, we had recorded approximately (i) \$200.6 million for redeemable equity securities and (ii) \$39.1 million as a liability for unrecognized income tax benefits and related interest and penalties. We excluded these amounts from the table below due to the uncertainty of the amounts to be paid, if any, as well as the timing of such payments. We also excluded \$215.6 million of net professional liability risk reserves (including \$40.4 million in current liabilities) from the table below because we do not characterize such reserves as contractual obligations and the unpaid settled claim amount at December 31, 2011 was not significant.

As of December 31, 2011, contractual obligations for each of the next five years ending December 31 and thereafter (including principal and interest) and other commitments are summarized in the table below. Interest rates at December 31, 2011 were used in the table to estimate interest payments on variable rate debt.

Contractual Obligations	Payments Due by Year Ending December 31,					
	2012	2013	2014	2015	2016	Thereafter
	(in thousands)					
Long-term debt (a)	\$ 249,435	\$ 246,752	\$ 350,391	\$ 290,579	\$ 991,054	\$ 2,520,413
Capital leases	22,722	17,468	15,934	15,678	12,013	95,417
Operating leases (b)	125,645	103,195	76,639	59,859	39,470	111,650
Interest rate swap contract	86,975	64,501	10,831	-	-	-
Physician commitments (c)	19,260	10,945	-	-	-	-
Other	200	200	200	200	200	600
Total contractual obligations	<u>\$ 504,237</u>	<u>\$ 443,061</u>	<u>\$ 453,995</u>	<u>\$ 366,316</u>	<u>\$ 1,042,737</u>	<u>\$ 2,728,080</u>
Other Commitments Not Recorded on our Consolidated Balance Sheet	Commitment Expiration by Year Ending December 31,					
	2012	2013	2014	2015	2016	Thereafter
	(in thousands)					
Letters of credit (d)	\$ 104,401	\$ -	\$ -	\$ -	\$ -	\$ -
Physician commitments (c)	26,394	16,357	-	-	-	-
Other (e)	161,191	34,830	2,000	-	-	-
Total commitments	<u>\$ 291,986</u>	<u>\$ 51,187</u>	<u>\$ 2,000</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>

- (a) For purposes of the above table, we assumed that we would repurchase our 3.75% Convertible Senior Subordinated Notes due 2028 on May 1, 2014 because the noteholders can unilaterally exercise their contractual right to require us to repurchase some or all of their notes on such date.
- (b) Amounts relate to obligations under operating leases for real property, real property master leases and equipment. The real property master leases are leases for buildings near our hospitals for which we guarantee a certain level of rental income to the owners of the property. We sublease space in these buildings to unrelated third parties. Future operating lease obligations are not recorded in our consolidated balance sheets.
- (c) See Note 1(e) and Note 13 to the Consolidated Financial Statements in Item 8 for information regarding physician and physician group guarantees and commitments.
- (d) Amount relates to outstanding letters of credit that principally serve as security for our workers' compensation self-insurance program and deposits for certain utility companies.
- (e) Other includes: (i) construction costs to build replacement hospitals for both Walton Regional Medical Center in Monroe, Georgia and the south campus facility at Poplar Bluff Regional Medical Center in Poplar Bluff, Missouri; (ii) purchase commitments for supplies; and (iii) other miscellaneous commitments.

## Impact of Inflation

The health care industry is labor intensive and subject to wage and related employee benefit expense increases, especially during periods of inflation and when there exists a shortage of skilled labor. A skilled nursing staff shortage throughout the health care industry has existed for the past several years and has caused nursing salaries to increase. We have addressed our nursing staff needs by increasing wages, improving hospital working conditions and fostering relationships with local nursing schools. We do not believe that the inflationary trend in nursing salaries or the nursing shortage will have an adverse effect on our results of operations.

Suppliers, utility companies and other vendors pass their cost increases to us in the form of higher prices. We believe that we have been able to partially offset increases in our operating costs by increasing prices, achieving quantity discounts for purchases through our group purchasing agreement and efficiently utilizing our resources. Although we have implemented cost control measures to curb increases in operating costs, we cannot predict our ability to recover or offset future cost increases from our many vendors.

## Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

We are subject to market risk due to changes in interest rates. To mitigate our exposure to interest rate volatility, a portion of our long-term debt is fixed rate and, if appropriate, we will consider entering into an interest rate swap contract. See Note 2 to the Consolidated Financial Statements in Item 8 for a discussion of our long-term debt. We do not believe that our overall market risk exposures will materially change during 2012.

As of December 31, 2011, the estimated fair value and carrying amount of our fixed rate debt, including capital lease obligations, were approximately \$1,529.1 million and \$1,463.7 million, respectively. The estimated fair value and carrying amount of our variable rate debt on such date were \$2,101.7 million and \$2,111.3 million, respectively. A hypothetical 1% increase in interest rates from those that were in effect at December 31, 2011 would impact our annualized interest expense by approximately \$14.1 million. Moreover, increases in interest rates would correspondingly increase our interest expense associated with any future borrowings. The table below summarizes principal cash flows and weighted average interest rates by expected maturity dates for our long-term debt and capital lease obligations that were outstanding at December 31, 2011.

	Years Ending December 31,						Totals
	2012	2013	2014	2015	2016	Thereafter	
	(in thousands, except interest rates)						
Fixed rate long-term debt, including capital leases	\$ 17,134	\$ 12,618	\$ 10,843	\$ 11,320	\$ 408,376	\$ 923,385	\$ 1,383,676
Weighted average interest rates	6.9%	6.8%	7.0%	7.0%	6.1%	7.4%	7.0%
Fixed rate convertible long-term debt	-	-	\$ 91,450 (a)	-	-	-	\$ 91,450
Weighted average interest rates	-	-	3.8%	-	-	-	3.8%
Variable rate long-term debt	\$ 68,375	\$ 68,375	\$ 86,500	\$ 122,750	\$ 449,000	\$ 1,330,000	\$ 2,125,000
Weighted average interest rates (b)	3.5%	3.5%	3.4%	3.4%	3.3%	4.5%	4.1%

- (a) For purposes of the above table, we assumed that we would repurchase our 3.75% Convertible Senior Subordinated Notes due 2028 on May 1, 2014 because the noteholders can unilaterally exercise their contractual right to require us to repurchase some or all of their notes on such date.
- (b) For purposes of the above table, we assumed that the interest rates on each of our variable rate long-term debt instruments at December 31, 2011 would remain in effect for the full term of such instruments.

We do not execute transactions or hold derivative financial instruments for trading purposes. However, pursuant to the requirements of the agreements underlying our former credit facilities, we entered into a receive variable/pay fixed interest rate swap contract in February 2007 that provides for us to pay a fixed interest rate of 6.7445% on the notional amount of such contract for its seven-year term. At December 31, 2011, the estimated fair value of the liability for our interest rate swap contract, which is discussed at Note 2(a) to the Consolidated Financial Statements in Item 8, was approximately \$162.3 million. A hypothetical 1% change in the LIBOR rate used in the valuation of our interest rate swap contract liability would have changed its estimated fair value by \$39.3 million.

We are exposed to market risk related to changes in the values of our available-for-sale securities, including those that are held by our insurance company subsidiaries. As more fully described at Note 5 to the Consolidated Financial Statements in Item 8, those investments have an estimated fair value and cost basis at December 31, 2011 of approximately \$246.8 million and \$245.5 million, respectively. We are also exposed to risk related to market illiquidity. For example, if one of our insurance subsidiaries requires cash beyond its usual requirements and we are unable to readily access the customary capital markets, we may have difficulty selling our investments in a timely manner or be forced to sell them at prices that are less than what we might have been able to obtain in an active market.

**Item 8. Financial Statements and Supplementary Data.**

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## **REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM**

Board of Directors and Stockholders  
Health Management Associates, Inc.

We have audited the accompanying consolidated balance sheets of Health Management Associates, Inc. as of December 31, 2011 and 2010, and the related consolidated statements of income, comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2011. Our audits also included the financial statement schedule listed in the Index at Item 15. These financial statements and schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements and schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Health Management Associates, Inc. at December 31, 2011 and 2010, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2011, in conformity with U.S. generally accepted accounting principles. Also, in our opinion, the related financial statement schedule, when considered in relation to the basic financial statements taken as a whole, presents fairly in all material respects the information set forth therein.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Health Management Associates, Inc.'s internal control over financial reporting as of December 31, 2011, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated February 27, 2012 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Certified Public Accountants  
Miami, Florida  
February 27, 2012

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**CONSOLIDATED STATEMENTS OF INCOME**  
(in thousands, except per share amounts)

	Years Ended December 31,		
	2011	2010	2009
Net revenue	\$ 5,804,451	\$ 5,092,166	\$ 4,536,106
Salaries and benefits	2,302,844	2,016,967	1,779,440
Supplies	776,598	703,426	637,663
Provision for doubtful accounts	716,856	624,753	553,639
Rent expense	154,279	122,983	100,990
Other operating expenses	1,067,980	892,465	788,051
Medicare and Medicaid HCIT incentive payments	(39,982)	-	-
Depreciation and amortization	267,900	241,873	234,883
Interest expense	222,747	211,673	217,938
Gains on early extinguishment of debt, net	-	-	(16,202)
Write-offs of deferred debt issuance costs and related other	24,595	-	444
Other	(1,771)	(8,797)	(4,980)
	<u>5,492,046</u>	<u>4,805,343</u>	<u>4,291,866</u>
Income from continuing operations before income taxes	312,405	286,823	244,240
Provision for income taxes	(106,071)	(101,049)	(82,937)
Income from continuing operations	<u>206,334</u>	<u>185,774</u>	<u>161,303</u>
Income (loss) from discontinued operations, including gains/losses on disposals, net of income taxes (see Notes 4 and 10)	<u>(2,409)</u>	<u>(13,526)</u>	<u>2,638</u>
Consolidated net income	203,925	172,248	163,941
Net income attributable to noncontrolling interests	<u>(25,215)</u>	<u>(22,179)</u>	<u>(25,759)</u>
Net income attributable to Health Management Associates, Inc.	<u>\$ 178,710</u>	<u>\$ 150,069</u>	<u>\$ 138,182</u>
Earnings (loss) per share attributable to Health Management Associates, Inc. common stockholders:			
Basic			
Continuing operations	\$ 0.72	\$ 0.66	\$ 0.55
Discontinued operations	(0.01)	(0.05)	0.01
Net income	<u>\$ 0.71</u>	<u>\$ 0.61</u>	<u>\$ 0.56</u>
Diluted			
Continuing operations	\$ 0.71	\$ 0.65	\$ 0.55
Discontinued operations	(0.01)	(0.05)	0.01
Net income	<u>\$ 0.70</u>	<u>\$ 0.60</u>	<u>\$ 0.56</u>
Weighted average number of shares outstanding:			
Basic	<u>251,541</u>	<u>248,272</u>	<u>245,381</u>
Diluted	<u>255,037</u>	<u>251,106</u>	<u>246,965</u>

See accompanying notes.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME**  
(in thousands)

	Years Ended December 31,		
	2011	2010	2009
Consolidated net income	\$ 203,925	\$ 172,248	\$ 163,941
Components of other comprehensive income (loss) before income taxes attributable to:			
Interest rate swap contract			
Changes in fair value	47,735	(17,646)	85,923
Reclassification adjustments for amortization of expense into net income	10,384	-	-
Net activity attributable to the interest rate swap contract	58,119	(17,646)	85,923
Available-for-sale securities			
Unrealized gains (losses) on available-for-sale securities, net	(117)	2,473	2,086
Adjustments for net (gains) losses reclassified into net income	(1,020)	(2,143)	-
Net activity attributable to available-for-sale securities	(1,137)	330	2,086
Other comprehensive income (loss) before income taxes	56,982	(17,316)	88,009
Income tax (expense) benefit related to items of other comprehensive income (loss)	(21,298)	6,434	(38,337)
Other comprehensive income (loss), net	35,684	(10,882)	49,672
Total consolidated comprehensive income	239,609	161,366	213,613
Total comprehensive income attributable to noncontrolling interests	(25,215)	(22,179)	(25,759)
Total comprehensive income attributable to Health Management Associates, Inc. common stockholders	\$ 214,394	\$ 139,187	\$ 187,854

See accompanying notes.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**CONSOLIDATED BALANCE SHEETS**  
(in thousands, except per share amounts)

	<b>December 31,</b>	
	<b>2011</b>	<b>2010</b>
<b>ASSETS</b>		
Current assets:		
Cash and cash equivalents	\$ 64,143	\$ 101,812
Available-for-sale securities	122,277	57,327
Accounts receivable, less allowances for doubtful accounts of \$578,972 and \$495,486 at December 31, 2011 and 2010, respectively	903,517	759,131
Supplies, at cost (first-in, first-out method)	156,529	137,214
Prepaid expenses	59,066	46,867
Prepaid and recoverable income taxes	61,756	44,961
Restricted funds	28,289	39,684
Assets of discontinued operations	14,561	11,384
Total current assets	<u>1,410,138</u>	<u>1,198,380</u>
Property, plant and equipment:		
Land and improvements	249,842	201,278
Buildings and improvements	2,848,185	2,431,910
Leasehold improvements	259,048	200,538
Equipment	1,565,236	1,332,064
Construction in progress	164,185	99,645
	<u>5,086,496</u>	<u>4,265,435</u>
Accumulated depreciation and amortization	<u>(1,823,324)</u>	<u>(1,602,488)</u>
Net property, plant and equipment	<u>3,263,172</u>	<u>2,662,947</u>
Restricted funds	96,244	51,067
Goodwill	999,380	909,470
Deferred charges and other assets	<u>235,255</u>	<u>88,221</u>
Total assets	<u>\$ 6,004,189</u>	<u>\$ 4,910,085</u>
<b>LIABILITIES AND STOCKHOLDERS' EQUITY</b>		
Accounts payable	\$ 198,120	\$ 172,501
Accrued payroll and related taxes	80,281	83,286
Accrued expenses and other liabilities	368,790	226,125
Due to third party payors	20,658	11,921
Deferred income taxes	50,466	27,052
Current maturities of long-term debt and capital lease obligations	85,509	34,745
Total current liabilities	<u>803,824</u>	<u>555,630</u>
Deferred income taxes	234,080	157,177
Long-term debt and capital lease obligations, less current maturities	3,489,489	2,983,719
Other long-term liabilities	491,037	478,586
Total liabilities	<u>5,018,430</u>	<u>4,175,112</u>
Redeemable equity securities	200,643	201,487
Stockholders' equity:		
Health Management Associates, Inc. equity:		
Preferred stock, \$0.01 par value, 5,000 shares authorized, none issued	-	-
Common stock, Class A, \$0.01 par value, 750,000 shares authorized, 254,156 shares and 250,880 shares issued at December 31, 2011 and 2010, respectively	2,542	2,509
Accumulated other comprehensive income (loss), net of income taxes	(95,440)	(131,124)
Additional paid-in capital	156,859	123,040
Retained earnings	705,180	526,470
Total Health Management Associates, Inc. stockholders' equity	<u>769,141</u>	<u>520,895</u>
Noncontrolling interests	15,975	12,591
Total stockholders' equity	<u>785,116</u>	<u>533,486</u>
Total liabilities and stockholders' equity	<u>\$ 6,004,189</u>	<u>\$ 4,910,085</u>

See accompanying notes.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY**  
**Years Ended December 31, 2011, 2010 and 2009**  
**(in thousands)**

	Health Management Associates, Inc.						
	Common Stock		Accumulated Other Comprehensive Income (Loss), Net	Additional Paid-in Capital	Retained Earnings	Noncontrolling Interests	Total Stockholders' Equity
	Shares	Par Value					
Balances at January 1, 2009	244,221	\$ 2,442	\$ (169,914)	\$ 108,374	\$ 238,219	\$ 106,690	\$ 285,811
Net income	-	-	-	-	138,182	25,759	163,941
Unrealized gains (losses) on available-for-sale securities and reclassifications into net income, net	-	-	1,351	-	-	-	1,351
Change in fair value of interest rate swap contract and amortization of expense into net income, net	-	-	48,321	-	-	-	48,321
Exercises of stock options and related tax matters	1,632	16	-	10,734	-	-	10,750
Issuances of deferred stock and restricted stock and related tax matters	2,664	27	-	(1,376)	-	-	(1,349)
Stock-based compensation expense	-	-	-	10,867	-	-	10,867
Distributions to noncontrolling shareholders	-	-	-	-	-	(29,227)	(29,227)
Incremental costs of certain transactions with noncontrolling shareholders	-	-	-	(1,054)	-	-	(1,054)
Restructuring of a joint venture with Novant Health, Inc., net (see Note 4)	-	-	-	(31,014)	-	(28,206)	(59,220)
Reclassification to redeemable equity securities	-	-	-	-	-	(68,571)	(68,571)
Balances at December 31, 2009	248,517	2,485	(120,242)	96,531	376,401	6,445	361,620
Net income	-	-	-	-	150,069	22,179	172,248
Unrealized gains (losses) on available-for-sale securities and reclassifications into net income, net	-	-	221	-	-	-	221
Change in fair value of interest rate swap contract and amortization of expense into net income, net	-	-	(11,103)	-	-	-	(11,103)
Exercises of stock options and related tax matters	1,094	11	-	11,328	-	-	11,339
Issuances of deferred stock and restricted stock and related tax matters	1,269	13	-	(3,185)	-	-	(3,172)
Stock-based compensation expense	-	-	-	18,366	-	-	18,366
Distributions to noncontrolling shareholders	-	-	-	-	-	(19,598)	(19,598)
Noncontrolling shareholder interests in an acquired business	-	-	-	-	-	3,565	3,565
Balances at December 31, 2010	250,880	2,509	(131,124)	123,040	526,470	12,591	533,486
Net income	-	-	-	-	178,710	25,215	203,925
Unrealized gains (losses) on available-for-sale securities and reclassifications into net income, net	-	-	(741)	-	-	-	(741)
Change in fair value of interest rate swap contract and amortization of expense into net income, net	-	-	36,425	-	-	-	36,425
Exercises of stock options and related tax matters	1,563	16	-	16,237	-	-	16,253
Issuances of deferred stock and restricted stock and related tax matters	1,713	17	-	(7,587)	-	-	(7,570)
Stock-based compensation expense	-	-	-	25,169	-	-	25,169
Distributions to noncontrolling shareholders	-	-	-	-	-	(25,394)	(25,394)
Noncontrolling shareholder interests in acquired businesses	-	-	-	-	-	3,563	3,563
Balances at December 31, 2011	254,156	\$ 2,542	\$ (95,440)	\$ 156,859	\$ 705,180	\$ 15,975	\$ 785,116

See accompanying notes.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**CONSOLIDATED STATEMENTS OF CASH FLOWS**  
(in thousands)

	<u>Years Ended December 31,</u>		
	<u>2011</u>	<u>2010</u>	<u>2009</u>
Cash flows from operating activities:			
Consolidated net income	\$ 203,925	\$ 172,248	\$ 163,941
Adjustments to reconcile consolidated net income to net cash provided by continuing operating activities:			
Depreciation and amortization	274,526	248,583	241,683
Amortization related to interest rate swap contract	10,384	-	-
Fair value adjustment related to interest rate swap contract	5,979	-	-
Provision for doubtful accounts	716,856	624,753	553,639
Stock-based compensation expense	25,169	18,366	10,867
Losses (gains) on sales of assets, net	1,325	(711)	(1,228)
Gains on sales of available-for-sale securities, net	(518)	(4,328)	(1,384)
Gain on early extinguishment of debt, net	-	-	(16,202)
Write-offs of deferred debt issuance costs	24,045	-	444
Deferred income tax expense	79,159	20,311	90,467
Changes in assets and liabilities of continuing operations, net of the effects of acquisitions:			
Accounts receivable	(870,898)	(731,607)	(595,780)
Supplies	(3,108)	(14,250)	(3,917)
Prepaid expenses	(8,271)	(6,393)	(348)
Prepaid and recoverable income taxes	(18,987)	31,020	881
Deferred charges and other long-term assets	(5,785)	5,382	(12,025)
Accounts payable	23,380	31,699	(21,296)
Accrued expenses and other liabilities	87,431	27,370	27,690
Equity compensation excess income tax benefits	(2,999)	(1,278)	(218)
(Income) loss from discontinued operations, net	2,409	13,526	(2,638)
Net cash provided by continuing operating activities	<u>544,022</u>	<u>434,691</u>	<u>434,576</u>
Cash flows from investing activities:			
Acquisitions of hospitals and other ancillary health care businesses	(582,090)	(191,454)	(138,764)
Additions to property, plant and equipment	(302,046)	(209,108)	(198,878)
Proceeds from sales of assets and insurance recoveries	2,765	3,150	5,326
Proceeds from sales of discontinued operations	4,851	26,360	-
Purchases of available-for-sale securities	(1,385,580)	(921,724)	(86,527)
Proceeds from sales of available-for-sale securities	1,321,398	904,881	50,000
Decrease (increase) in restricted funds, net	(35,309)	(5,758)	11,590
Net cash used in continuing investing activities	<u>(976,011)</u>	<u>(393,653)</u>	<u>(357,253)</u>

See accompanying notes.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**CONSOLIDATED STATEMENTS OF CASH FLOWS (continued)**  
(in thousands)

	<u>Years Ended December 31,</u>		
	<u>2011</u>	<u>2010</u>	<u>2009</u>
Cash flows from financing activities:			
Proceeds from long-term borrowings	\$ 3,356,970	\$ -	\$ 38,000
Principal payments on debt and capital lease obligations	(2,869,380)	(40,147)	(127,073)
Payments of debt issuance costs	(75,149)	-	-
Repurchases of convertible debt securities in the open market	-	-	(67,714)
Proceeds from exercises of stock options	14,067	7,469	9,699
Cash received from noncontrolling shareholders, net of certain costs	-	2,547	54,796
Cash payments to noncontrolling shareholders	(28,284)	(20,630)	(35,377)
Equity compensation excess income tax benefits	2,999	1,278	218
Net cash provided by (used in) continuing financing activities	<u>401,223</u>	<u>(49,483)</u>	<u>(127,451)</u>
Net decrease in cash and cash equivalents before discontinued operations	(30,766)	(8,445)	(50,128)
Net increases (decreases) in cash and cash equivalents from discontinued operations:			
Operating activities	5,991	5,672	14,593
Investing activities (see Note 10)	(12,894)	(1,433)	(1,503)
Financing activities	<u>-</u>	<u>-</u>	<u>(558)</u>
Net decrease in cash and cash equivalents	(37,669)	(4,206)	(37,596)
Cash and cash equivalents at the beginning of the year	101,812	106,018	143,614
Cash and cash equivalents at the end of the year	<u>\$ 64,143</u>	<u>\$ 101,812</u>	<u>\$ 106,018</u>
Supplemental disclosures of cash flow information:			
Cash paid during the year for:			
Interest, net of amounts capitalized	<u>\$ 188,734</u>	<u>\$ 204,576</u>	<u>\$ 204,718</u>
Income taxes	<u>\$ 50,651</u>	<u>\$ 69,443</u>	<u>\$ 32,124</u>

See accompanying notes.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**December 31, 2011**

**1. Business and Summary of Significant Accounting Policies**

Health Management Associates, Inc. by and through its subsidiaries (collectively, the "Company") provides health care services to patients in hospitals and other health care facilities in non-urban communities located primarily in the southeastern United States. As of December 31, 2011, the Company operated 66 hospitals in fifteen states with a total of 10,330 licensed beds. At such date, twenty-two of the Company's hospitals were located in Florida and ten hospitals were located in each of Mississippi and Tennessee. See Note 10 for information about one of the Company's Tennessee-based hospitals with a lease agreement that will expire in May 2012 and will not be renewed. Also, see Note 15 for acquisition activity subsequent to December 31, 2011.

Unless specifically indicated otherwise, all amounts and percentages presented in the notes below are exclusive of the Company's discontinued operations, which are identified at Note 10.

The preparation of financial statements in conformity with U.S. generally accepted accounting principles ("GAAP") requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Certain amounts in the consolidated financial statements have been reclassified in prior years to conform to the current year presentation. Such reclassifications primarily related to discontinued operations.

The Company consistently applies the accounting policies described below.

*a. Principles of consolidation*

The consolidated financial statements include the accounts of the Company and its subsidiaries, all of which are controlled by the Company through majority voting control. All significant intercompany accounts and transactions have been eliminated. The Company uses the equity method of accounting for investments in entities in which it exhibits significant influence, but not control, and has an ownership interest ranging from 20% to 50%.

For consolidation and variable interest entity disclosure purposes, management evaluates circumstances where the Company has ownership, contractual or other financial interests that may result in its (i) ability to direct the activities of an entity that most significantly impact such entity's economic performance and/or (ii) obligation to absorb the losses of, or the right to receive the benefits from, an entity that could potentially be significant to that entity; however, no such arrangements that would be material to the Company's consolidated financial position or results of operations have been identified.

*b. Cash and cash equivalents*

Cash and cash equivalents include all highly liquid investments with an original maturity of three months or less. The Company's cash equivalents primarily consist of investment grade financial instruments.

*c. Available-for-sale securities*

The Company's investments in debt securities and shares in publicly traded stocks and mutual funds have been designated by management as available-for-sale securities, as defined by GAAP. The estimated fair values of such securities are based on quoted market prices and pricing valuation models. Changes in temporary unrealized gains and losses are recorded as adjustments to other comprehensive income, net of income taxes. Periodically, management performs an evaluative assessment of individual securities to determine whether declines in fair value are other-than-temporary. Management considers various quantitative, qualitative and judgmental factors when performing its evaluation, including, but not limited to, the nature of the security being analyzed and the length of time and extent to which a security's fair value is below its historical cost. The weighted average cost method is used to calculate the historical cost basis of securities that are sold. Also, see Notes 5 and 11 for more information regarding the Company's available-for-sale securities.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**1. Business and Summary of Significant Accounting Policies (continued)**

*d. Property, plant and equipment*

Property, plant and equipment are stated at cost and include major expenditures that extend an asset's useful life. Ordinary repair and maintenance costs (e.g., medical equipment adjustments, painting, cleaning, etc.) are expensed as incurred. Depreciation and amortization are computed using the straight-line method over the estimated useful lives of the underlying assets. Estimated useful lives for buildings and improvements range from fifteen to forty years and for equipment range from three to fifteen years. Leasehold improvements, capital lease assets and other assets of a similar nature are amortized on a straight-line basis over the shorter of the term of the respective lease or the useful life of the underlying asset. Depreciation expense was approximately \$219.3 million, \$207.2 million and \$202.8 million during the years ended December 31, 2011, 2010 and 2009, respectively.

*e. Deferred debt issuance costs, goodwill and other long-lived assets*

*Deferred debt issuance costs.* Deferred charges and other assets include deferred debt issuance costs that are being amortized over the estimated economic life of the related debt using the effective interest method. A rollforward of the Company's deferred debt issuance costs is presented in the table below (in thousands).

	<b>Years Ended December 31,</b>		
	<b>2011</b>	<b>2010</b>	<b>2009</b>
Balances at the beginning of the year	\$ 48,515	\$ 48,515	\$ 50,520
Costs associated with the issuance of long-term debt	75,149	-	-
Write-offs, primarily in connection with a debt refinancing (see Note 2)	(56,463)	-	(444)
Repurchases of convertible debt securities	-	-	(1,561)
Balances at the end of the year	<u>\$ 67,201</u>	<u>\$ 48,515</u>	<u>\$ 48,515</u>

Accumulated amortization of deferred debt issuance costs was approximately \$3.1 million and \$27.9 million at December 31, 2011 and 2010, respectively. Amortization of deferred debt issuance costs was \$7.6 million, \$7.1 million and \$7.6 million during the years ended December 31, 2011, 2010 and 2009, respectively. Future amortization of deferred debt issuance costs is expected to approximate \$11.3 million, \$11.0 million, \$10.5 million, \$9.9 million and \$8.4 million during the years ending December 31, 2012, 2013, 2014, 2015 and 2016, respectively.

*Goodwill.* GAAP calls for goodwill (i.e., the excess of cost over acquired net assets) and intangible assets with indefinite useful lives to be tested for impairment annually and whenever circumstances indicate that a possible impairment might exist. When performing goodwill impairment tests prior to 2011, management initially compared the estimated fair values of each reporting unit's net assets, including allocated home office net assets, to the corresponding carrying amounts on the Company's consolidated balance sheet. The estimated fair values of the Company's reporting units were determined using a market approach methodology based on net revenue multiples. Management also considered a valuation methodology using discounted cash flows and a market approach valuation methodology based on comparable transactions. If the estimated fair value of a reporting unit's net assets was less than the balance sheet carrying amount, management determined the implied fair value of the reporting unit's goodwill, compared such fair value to the corresponding carrying amount and, if necessary, recorded a goodwill impairment charge.

During September 2011, the Financial Accounting Standards Board amended the accounting standards in GAAP as they relate to the annual test for goodwill impairment (the "Goodwill Update"). The Goodwill Update allows, but does not require, an initial assessment of qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount for the purpose of determining if detailed quantitative goodwill impairment testing is necessary. Public companies were required to adopt the provisions of the Goodwill Update during interim and annual periods beginning after December 15, 2011; however, early adoption was permitted. Management elected to early adopt the Goodwill Update in connection with the Company's annual goodwill impairment testing on October 1, 2011. The Company's adoption of the Goodwill Update did not have a material impact on its annual goodwill impairment testing or the results therefrom. Specifically, the qualitative factors reviewed by management did not reveal any circumstances whereby detailed quantitative goodwill impairment testing was necessary at the reporting unit level. There were no goodwill impairment charges in continuing operations during the years ended December 31, 2011, 2010 and 2009.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**1. Business and Summary of Significant Accounting Policies (continued)**

Reporting units are one level below the operating segment level (see Note 1(m)). However, after consideration of the relevant GAAP aggregation rules, management determined that the Company's goodwill impairment testing should be performed at the divisional operating level. Goodwill is discretely allocated to the Company's reporting units (i.e., each hospital's goodwill is included as a component of the aggregate reporting unit goodwill being evaluated during the impairment analysis).

*Physician and Physician Group Guarantees.* Deferred charges and other assets include estimated physician and physician group guarantee costs, which aggregated approximately \$88.0 million and \$60.7 million at December 31, 2011 and 2010, respectively. Such amounts are being amortized over the required service periods of the underlying contractual arrangements. The corresponding accumulated amortization was \$38.8 million and \$30.9 million at December 31, 2011 and 2010, respectively. Amortization expense related to estimated physician and physician group guarantee costs was \$29.2 million, \$21.7 million and \$21.3 million during the years ended December 31, 2011, 2010 and 2009, respectively. Based on the December 31, 2011 balances, future amortization expense is expected to be \$37.0 million, \$10.0 million and \$2.2 million during the years ending December 31, 2012, 2013 and 2014, respectively. See Note 13 for further information regarding physician and physician group guarantees.

*Intangible Assets.* Included in deferred charges and other assets at December 31, 2011 were intangible assets of approximately \$51.2 million relating to contractual rights to operate hospitals and other health care facilities and non-compete arrangements, net of \$2.0 million of accumulated amortization. See Note 4 for information about these intangible assets that were acquired during 2011. Future amortization of such assets is expected to approximate \$7.9 million, \$7.9 million, \$7.9 million, \$7.1 million and \$4.2 million during the years ending December 31, 2012, 2013, 2014, 2015 and 2016, respectively.

*Impairment of Long-lived Assets.* When events, circumstances or operating results indicate that the carrying values of long-lived assets and/or identifiable intangible assets (excluding goodwill) that are expected to be held and used might be impaired, management prepares projections of the undiscounted future cash flows expected to result from the use of the assets and their eventual disposition. If the projections indicate that the recorded amounts are not expected to be recoverable, such long-lived assets are reduced to their estimated fair values, as determined by management through various discrete valuation analyses, and the Company records an impairment charge. Long-lived assets to be disposed of are reported at the lower of their carrying amount or estimated fair value, less costs to sell. The estimates of fair value are based on recent sales of similar assets, market analyses, pending disposition transactions and market responses based on discussions with, and offers received from, potential buyers.

There were no long-lived asset impairment charges that were material to the Company's continuing operations during the years ended December 31, 2011, 2010 and 2009. During the years ended December 31, 2011, 2010 and 2009, the Company recorded long-lived asset and goodwill impairment charges of approximately \$3.6 million, \$8.4 million and \$4.6 million, respectively, in discontinued operations (see Note 10).

*f. Net revenue, cost of revenue and related other*

*Net Revenue.* The Company records gross patient service charges on the accrual basis in the period that the services are rendered. Net revenue represents gross patient service charges less provisions for contractual adjustments. Approximately 40%, 41% and 41% of net revenue during the years ended December 31, 2011, 2010 and 2009, respectively, related to services rendered to patients covered by Medicare and various state Medicaid programs. Payments for services rendered to patients covered by these programs are generally less than billed charges and, therefore, provisions for contractual adjustments are made to reduce patient charges to the estimated cash receipts based on each program's principles of payment/reimbursement (i.e., either prospectively determined or retrospectively determined costs). Final settlements under these programs are subject to administrative review and audit and, accordingly, the Company periodically provides reserves for the adjustments that may ultimately result therefrom. Such adjustments were not material to the Company's consolidated results of operations during the years presented herein. Laws, rules and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, estimates recorded in the consolidated financial statements and disclosed in the accompanying notes may change in the future and such changes in estimates, if any, will be recorded in the Company's operating results in the period they are identified by management. Revenue and receivables from government programs are significant to the Company's operations; however, management does not believe that there are substantive credit risks associated with such programs. There are no other concentrations of revenue or accounts receivable with any individual payor that subject the Company to significant credit or other risks.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**1. Business and Summary of Significant Accounting Policies (continued)**

Estimates for contractual allowances under managed care health plans are primarily based on the payment terms of contractual arrangements, such as predetermined rates per diagnosis, per diem rates or discounted fee for service rates.

Net revenue is presented net of provisions for contractual adjustments and uninsured patient discounts. The Company's provisions for contractual adjustments were approximately \$19,433 million, \$15,612 million and \$12,589 million during the years ended December 31, 2011, 2010 and 2009, respectively. In the ordinary course of business, the Company provides services to patients who are financially unable to pay for their care. Accounts identified as charity and indigent care are not recognized in net revenue. The Company maintains a uniform policy whereby patient account balances are characterized as charity and indigent care only if the patient meets certain percentages of the federal poverty level guidelines. Local hospital personnel and the Company's collection agencies pursue payments on accounts receivable from patients who do not meet such criteria. Management monitors the levels of charity and indigent care provided by the Company's hospitals and other health care facilities and the procedures employed to identify and account for those patients. Most states include an estimate of charity and indigent care costs in the determination of a hospital's eligibility for Medicaid disproportionate share payments.

See Note 12 for a change in GAAP that will affect the Company's presentation of net revenue in future periods.

*Uncompensated Patient Care.* To quantify the overall impact of, and trends related to, uninsured accounts, management believes that it is beneficial to view the Company's: (i) foregone/unrecognized revenue for charity and indigent care; (ii) uninsured self-pay patient discounts (i.e., the Company discounts its gross charges to uninsured patients for non-elective procedures by 60% or more); and (iii) provision for doubtful accounts, which is collectively referred to herein as "uncompensated patient care," in combination rather than separately. Management estimates the costs of the Company's uncompensated patient care using a cost-to-charge ratio that is calculated by dividing patient care costs by gross patient charges. Those costs include select direct and indirect costs such as salaries and benefits, supplies, depreciation and amortization, rent and other operating expenses. The table below sets forth the estimated costs of the Company's uncompensated patient care (in thousands).

	Years Ended December 31,		
	2011	2010	2009
Charity and indigent care foregone/unrecognized revenue (based on established rates)	\$ 91,927	\$ 88,797	\$ 79,459
Uninsured self-pay patient discounts	939,763	789,370	641,911
Provision for doubtful accounts	716,856	624,753	553,639
	<u>1,748,546</u>	<u>1,502,920</u>	<u>1,275,009</u>
Cost-to-charge ratio	21.8%	22.3%	22.1%
Estimated costs of uncompensated patient care	<u>\$ 381,183</u>	<u>\$ 335,151</u>	<u>\$ 281,777</u>

*Cost of Revenue.* The presentation of costs and expenses in the Company's consolidated statements of income does not differentiate between costs of revenue and other costs because substantially all of such costs and expenses are related to providing health care services. Furthermore, management believes that the natural classification of expenses is the most meaningful presentation of the Company's operations. Amounts that could be classified as general and administrative expenses include the costs of the Company's home office, which were approximately \$168.8 million, \$138.7 million and \$117.7 million during the years ended December 2011, 2010 and 2009, respectively.

*g. Accounts receivable and allowances for doubtful accounts*

The Company grants credit without requiring collateral from its patients, most of whom live near the Company's hospitals and are insured under third party payor agreements. In certain circumstances, the Company charges interest on past due accounts receivable (delinquent accounts are identified by reference to contractual or other payment terms); however, such interest amounts were not material to the years presented herein. The credit risk for non-governmental accounts receivable is limited due to the large number of insurance companies and other payors that provide payment and reimbursement for patient services. Accounts receivable are reported net of estimated allowances for doubtful accounts.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**1. Business and Summary of Significant Accounting Policies (continued)**

Collection of accounts receivable from third party payors and patients is the Company's primary source of cash and is therefore critical to its successful operating performance. Accordingly, management closely monitors the Company's cash collection trends and the aging of accounts receivable. Collection risks principally relate to uninsured patient accounts and patient accounts for which the primary insurance payor has paid but patient responsibility amounts (generally deductibles and co-payments) remain outstanding. Provisions for doubtful accounts are primarily estimated based on cash collection analyses by payor classification and accounts receivable aging reports. When considering the adequacy of allowances for doubtful accounts, the Company's accounts receivable balances are routinely reviewed in conjunction with historical collection rates, health care industry trends/indicators and other business and economic conditions that might reasonably be expected to affect the collectibility of patient accounts. Accounts receivable are written off after collection efforts have been pursued in accordance with the Company's policies and procedures. Accounts written off as uncollectible are deducted from the allowance for doubtful accounts and subsequent recoveries are netted against the provision for doubtful accounts. Changes in payor mix, general economic conditions or federal and state government health care coverage could each have a material adverse effect on the Company's accounts receivable collections, cash flows and results of operations.

*h. Professional liability claims*

Reserves for self-insured professional liability indemnity claims and related expenses, including attorneys' fees and other related costs of litigation that have been incurred and will be incurred in the future, are determined using actuarially-based techniques and methodologies. The data used to develop such reserves is based on asserted and unasserted claim information that has been accumulated by the Company's incident reporting system, historical loss payment patterns and industry trends. Such long-term liabilities have been discounted to their estimated present values. Management selects a discount rate that represents a risk-free interest rate correlating to the period when the claims are projected to be paid. The Company's discounted reserves at December 31, 2010 did not include any amounts for estimated losses that were expected to be covered by reinsurance policies; however, see Note 12 for new accounting guidance that the Company adopted effective January 1, 2011.

The reserves for self-insured professional liability claims and expenses are periodically reviewed and adjustments thereto are recorded as more information about claim trends becomes known to management. Adjustments to the reserves are recognized in the Company's operating results in the period that the change in estimate is identified. See Note 13 for further discussion of the Company's professional liability risks and related matters.

*i. Self-insured workers' compensation and health and welfare programs*

The Company provides (i) income continuance to, and reimburses certain health care costs of, its disabled employees (collectively, "workers' compensation") and (ii) health and welfare benefits to its employees, their spouses and certain beneficiaries. While such employee benefit programs are primarily self-insured, stop-loss insurance policies are maintained in amounts deemed appropriate by management. Nevertheless, there can be no assurances that the amount of stop-loss insurance coverage will be adequate for such Company programs.

The Company records estimated liabilities for both reported and incurred but not reported workers' compensation and health and welfare claims based on historical loss experience and other information provided by the Company's third party administrators. The long-term liabilities for workers' compensation are determined using actuarially-based techniques and methodologies and are discounted to their estimated present values. Management selects a discount rate that represents a risk-free interest rate correlating to the period when such benefits are projected to be paid. The Company's liabilities at December 31, 2010 for workers' compensation and health and welfare benefits did not include any amounts for benefits that were expected to be covered by stop-loss policies; however, see Note 12 for new accounting guidance that the Company adopted effective January 1, 2011. Although there can be no assurances, management believes that the liabilities included in the Company's consolidated financial statements for these self-insured programs are adequate and reasonable. If the actual costs of these programs exceed management's estimates, the liabilities could be materially adversely affected.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**1. Business and Summary of Significant Accounting Policies (continued)**

*j. Fair value of financial instruments*

Cash and cash equivalents, net accounts receivable, accounts payable and accrued expenses and other liabilities are reflected in the consolidated balance sheets at their estimated fair values primarily due to their short-term nature. The estimated fair values of long-term debt and available-for-sale securities, which are disclosed at Notes 2 and 5, respectively, were primarily determined by reference to quoted market prices, pricing valuation models and/or bid and ask prices in the relevant market. Additionally, see Note 5 regarding the estimated fair value of the Company's interest rate swap contract, including valuation methods and significant assumptions.

*k. Noncontrolling interests in consolidated entities and redeemable equity securities*

The consolidated financial statements include all assets, liabilities, revenue and expenses of certain entities that are controlled by the Company but not wholly owned. The Company records noncontrolling interests and redeemable equity securities to reflect the ownership interests and other rights of the noncontrolling shareholders. The sale of a noncontrolling interest, where control of the affected entity is retained, is treated as an equity transaction. Moreover, direct and incremental costs of transactions with noncontrolling shareholders that change the ownership percentage of Health Management Associates, Inc. in a consolidated entity are considered part of the related equity transaction if control is maintained by the parent.

Redeemable equity securities with redemption features that are not solely within the Company's control are classified outside of permanent equity. Those securities are initially recorded at their estimated fair value on the date of issuance. Securities that are currently redeemable or redeemable after the passage of time are adjusted to their redemption value as changes occur. If it is unlikely that a redeemable equity security will ever require redemption (e.g., management does not expect that a triggering contingency will occur, etc.), then subsequent adjustments to the initially recorded amount will only be recognized in the period that a redemption becomes probable. See Note 4 for further information regarding the Company's redeemable equity securities.

*l. Income taxes*

Deferred income tax assets and liabilities are determined based on differences between financial reporting and tax bases of assets and liabilities and are measured using the enacted tax rates and laws that are expected to apply to taxable income in the periods in which the underlying deferred tax asset or liability is expected to be realized or settled. Management must make estimates when recording the Company's provision for income taxes, including conclusions regarding deferred tax assets and deferred tax liabilities, as well as valuation allowances that might be required to offset deferred tax assets. Management estimates valuation allowances to reduce deferred tax assets to the amounts it believes are more likely than not to be realized in future periods. When establishing valuation allowances, management considers all relevant information, including ongoing tax planning strategies. Management adjusts valuation allowance estimates and records the impact of such changes in the Company's income tax provision in the period that management determines that the probability of deferred tax asset realization has changed.

The Company operates in multiple states with varying tax laws and is subject to both federal and state audits of its tax filings. Management estimates tax reserves to adequately provide for audit adjustments, if any. Actual audit results could vary from the estimates recorded by the Company. Recorded tax reserves and the changes therein were not material to the Company's consolidated financial position or its results of operations during the years presented herein.

See Note 6 for further information regarding income taxes.

*m. Segment reporting*

GAAP requires that a company with publicly traded debt or equity securities report annual and interim financial and other information about its reportable operating segments. Operating segments are components of an enterprise for which separate financial information is available and such information is evaluated regularly by the chief operating decision maker when deciding how to allocate resources and assess performance. GAAP allows

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**1. Business and Summary of Significant Accounting Policies (continued)**

aggregation of similar operating segments into a single operating segment if the businesses have comparable economic characteristics and are otherwise considered alike. The Company's operating segments, which provide health care services to patients in owned and leased facilities, offer comparable services, have the same types of patients, operate in a consistent manner and have similar economic and regulatory characteristics. Accordingly, such operating segments have been aggregated into a single reportable segment.

*n. Discontinued operations*

GAAP requires that a component of an entity be reported as discontinued operations if, among other things, such component: (i) has been disposed of or is classified as held for sale; (ii) has operations and cash flows that can be clearly distinguished from the rest of the reporting entity; and (iii) will be eliminated from the ongoing operations of the reporting entity. In the period that a component of the Company meets such criteria, its results of operations and cash flows for current and prior periods are reclassified to discontinued operations and the assets and liabilities of the related disposal group are segregated on the consolidated balance sheet. See Note 10 for information regarding the Company's discontinued operations.

*o. Loss contingencies*

Management regularly reviews the status of the Company's legal and regulatory matters and assesses the potential financial exposure thereof. If the potential loss from any claim, lawsuit or regulatory proceeding is considered probable and the amount can be reasonably estimated, the Company records a reserve. Significant judgment is required when determining probability and whether an exposure is reasonably estimable. The actual costs resulting from the final resolution of claims, lawsuits and regulatory matters may vary significantly from management's estimates because, among other things, estimating such financial exposure requires consideration of substantial uncertainties. Changes in the estimates of financial exposure for legal matters and other loss contingencies could have a material impact on the Company's consolidated financial position and results of operations. Attorneys' fees and other costs of defending the Company in respect of claims, lawsuits and regulatory proceedings are expensed in the period such fees and costs are incurred, except as noted above at Note 1(h).

See Note 13 for information regarding the Company's material legal matters and other loss contingencies.

**2. Long-Term Debt**

The table below summarizes the Company's long-term debt and capital lease obligations (in thousands).

	<b>December 31,</b>	
	<b>2011</b>	<b>2010</b>
Revolving credit facilities (a)	\$ -	\$ -
Bank borrowings (a):		
New Term Loan A	725,000	-
New Term Loan B, net of a discount of approximately \$13,742 at December 31, 2011	1,386,258	-
Predecessor Term Loan	-	2,481,434
7.375% Senior Notes due 2020 (b)	875,000	-
6.125% Senior Notes due 2016, net of discounts of approximately \$1,584 and \$1,953 at December 31, 2011 and 2010, respectively (b)	398,416	398,047
3.75% Convertible Senior Subordinated Notes due 2028, net of discounts of approximately \$9,802 and \$13,352 at December 31, 2011 and 2010, respectively (c)	81,648	78,098
Installment notes and other unsecured long-term debt at interest rates ranging from 4.2% to 7.5%, payable through 2025	4,264	5,184
Capital lease obligations (see Note 3)	104,412	55,701
Long-term debt and capital lease obligations	3,574,998	3,018,464
Less current maturities	(85,509)	(34,745)
Long-term debt and capital lease obligations, less current maturities	<u>\$ 3,489,489</u>	<u>\$ 2,983,719</u>

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**2. Long-Term Debt (continued)**

**a. Bank Borrowings and Revolving Credit Facilities**

*New 2011 Bank Borrowings.* On November 18, 2011, the Company completed a restructuring of its long-term debt (the "2011 Debt Restructuring"), which included, among other things, new variable rate senior secured credit facilities with a syndicate of banks (the "New Credit Facilities"). The New Credit Facilities consist of: (i) a \$500.0 million five-year revolving credit facility (the "New Revolving Credit Agreement"); (ii) a \$725.0 million five-year term loan (the "New Term Loan A"); and (iii) a \$1.4 billion seven-year term loan (the "New Term Loan B"). The New Term Loan B was subject to an original issue discount of 1.0%. The Company used the net proceeds from the term loans under the New Credit Facilities, together with the net proceeds from the sale of its 7.375% Senior Notes due 2020, to repay all amounts outstanding under the Predecessor Credit Facilities and the Knoxville Credit Agreement (both of which are defined below).

The Company can elect whether interest on borrowings under the New Credit Facilities is calculated using LIBOR or the Prime Rate (as defined in the loan agreement) as its base rate; however, the base rate for the New Term Loan B is subject to a floor of 1.0% when the LIBOR option is selected. The effective interest rate, which fluctuates with changes in the underlying base rates, includes a spread above the base rate selected by the Company. The amount of the interest rate spread is predicated on, among other things, the Company's Consolidated Leverage Ratio (as defined in the loan agreement). The Company can elect differing interest rates for each of the debt instruments that comprise the New Credit Facilities. Interest is payable in arrears at the end of a calendar quarter or on the date that the selected interest duration period ends.

Beginning on March 31, 2012, the New Term Loan A will be repaid in equal quarterly installments in an aggregate annual amount equal to 7.5% of the principal amount thereof in each of the first two years of such facility, 10.0% in the third year, 15.0% in the fourth year and 60.0% in the fifth year. The New Term Loan B requires quarterly principal payments of \$3.5 million, beginning on March 31, 2012, and a balloon payment for the remaining outstanding balance at the end of the facility's seventh year. The Company has the right to prepay amounts outstanding under the New Credit Facilities at any time without penalty, other than a prepayment of the New Term Loan B, which is subject to a prepayment premium during the first year of the loan agreement equal to 1.0% of the principal amount prepaid. At December 31, 2011, the effective interest rates on the New Term Loan A and the New Term Loan B were 3.2% and 4.5%, respectively. Those rates remained unchanged as of February 17, 2012.

Throughout the New Revolving Credit Agreement's five-year term, the Company is obligated to pay commitment fees based on the amounts available for borrowing. The New Revolving Credit Agreement provides that the Company can borrow, on a revolving basis, up to an aggregate of \$500.0 million, as adjusted for outstanding standby letters of credit of up to \$75.0 million. As of February 17, 2012, standby letters of credit in favor of third parties of approximately \$51.9 million reduced the amount available for borrowing under the New Revolving Credit Agreement to \$448.1 million on such date. Although there were no amounts outstanding on either date, the effective interest rate on the variable rate New Revolving Credit Agreement was approximately 3.3% and 3.2% on December 31, 2011 and February 17, 2012, respectively.

The New Credit Facilities provide for a springing maturity of all amounts then outstanding to the date that is 91 days prior to the maturity date of the 2016 Senior Notes (as defined below) unless (i) the 2016 Senior Notes are first refinanced in full or (ii) the Company has liquidity at a predetermined date equal to \$200 million, plus the then outstanding principal amount of the 2016 Senior Notes. The New Credit Facilities are also generally subject to mandatory prepayment in amounts equal to: (i) 100% of the net cash proceeds received from certain asset sales, including insurance recoveries and condemnation events, subject to reinvestment provisions and the ratable offer requirements of other pari passu secured debt; (ii) 100% of the net cash proceeds from the Company's issuance of certain new debt; and (iii) 50% of the Company's Excess Cash Flow (as defined in the loan agreement) with step-downs of such percentage based on the Company's Consolidated Leverage Ratio.

The Company's obligations under the New Credit Facilities are guaranteed on a joint and several basis by all of the Company's material domestic wholly owned subsidiaries (other than certain exempted subsidiaries). As discussed below, the same subsidiaries also provide certain guarantees with respect to the Company's obligations under the 2016 Senior Notes and the 7.375% Senior Notes due 2020. Additionally, the obligations under the New Credit Facilities, as well as those of the 2016 Senior Notes and the Demand Note (as defined below), are secured on a pari passu basis by a substantial portion of the Company's assets (primarily those of the subsidiary guarantors under the New Credit Facilities). As a result, approximately \$526.7 million, \$92.4 million and \$1,957.8 million of the Company's net accounts receivable, supplies, and net property, plant and equipment, respectively, as presented in its consolidated balance sheet at December 31, 2011, collateralize the aforementioned credit facilities.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**2. Long-Term Debt (continued)**

The agreements underlying the New Credit Facilities contain covenants that, without prior consent of the lenders, limit certain of the Company's activities, including those relating to mergers; consolidations; the ability to secure additional indebtedness; sales, transfers and other dispositions of property and assets; capital expenditures; providing new guarantees; investing in joint ventures; and granting additional security interests. The New Credit Facilities also contain customary events of default and related cure provisions. Additionally, the Company is required to comply with certain financial covenants on a quarterly basis and its ability to pay cash dividends is subject to certain restrictions.

*Predecessor Bank Borrowings.* On March 1, 2007, the Company completed a recapitalization of its balance sheet, which included, among other things, \$3.25 billion in new variable rate senior secured credit facilities with a syndicate of banks (the "Predecessor Credit Facilities") that closed on February 16, 2007. The Predecessor Credit Facilities consisted of a seven-year \$2.75 billion term loan (the "Predecessor Term Loan") and a \$500.0 million six-year revolving credit facility (the "Predecessor Revolving Credit Agreement"). As part of the 2011 Debt Restructuring, the Company terminated the Predecessor Credit Facilities and repaid all of the principal and accrued interest outstanding thereunder on November 18, 2011.

The Predecessor Term Loan required (i) quarterly principal payments to amortize approximately 1% of the loan's face value during each year of the loan's term and (ii) a balloon payment for the remaining outstanding loan balance at the end of the agreement. The Company was also required to repay principal under the Predecessor Term Loan in an amount that was as much as 50% of its annual Excess Cash Flow, as such term was defined in the Predecessor Credit Facilities' loan agreement. Based on the annual Excess Cash Flow requirements of the Predecessor Credit Facilities, the Company made principal payments under the Predecessor Term Loan of approximately \$18.4 million during the year ended December 31, 2009. The Company also prepaid \$25.0 million of principal under the Predecessor Term Loan during such year. There were no annual Excess Cash Flow principal payments under the Predecessor Term Loan that were required during the years ended December 31, 2011 and 2010. In connection with the early termination of the Predecessor Credit Facilities and principal payments under the Predecessor Term Loan in advance of their original scheduled maturities, the Company wrote-off deferred debt issuance costs, net of accumulated amortization, of \$13.6 million and \$0.4 million during the years ended December 31, 2011 and 2009, respectively.

The Company could elect whether interest on the Predecessor Credit Facilities, which was payable quarterly in arrears, was calculated using LIBOR or prime as its base rate. The effective interest rate included a spread above the base rate selected by the Company and was subject to modification in certain circumstances. Additionally, the Company could elect differing base interest rates for the Predecessor Term Loan and the Predecessor Revolving Credit Agreement. Under the Predecessor Revolving Credit Agreement, the Company was also obligated to pay commitment fees based on the amounts available for borrowing. During February 2007, as required by the Predecessor Credit Facilities, the Company entered into a seven-year receive variable/pay fixed interest rate swap contract. The interest rate swap contract was not terminated as part of the 2011 Debt Restructuring. Although the Company is exposed to financial risk in the event of nonperformance by one or more of the counterparties to the contract, management does not anticipate nonperformance because the interest rate swap contract is in a liability position and would require the Company to make settlement payments to the counterparties in the event of a contract termination. The interest rate swap contract provides for the Company to pay interest at a fixed rate of 6.7445% on the contract's notional amount, which was originally expected to reasonably approximate the declining principal balance of the Predecessor Term Loan. At December 31, 2011, the notional amount of the Company's interest rate swap contract was approximately \$2,027.4 million. Management projects that \$87.0 million will be payable to the counterparties during the year ending December 31, 2012; however, the aggregate payments through the contract's expiration in February 2014, as well as the specific timing thereof, are subject to change based on, among other things, future LIBOR rates. See Note 5 for discussion of the estimated fair value of the Company's interest rate swap contract, including valuation methods and significant assumptions, and Note 11 for the accounting afforded the interest rate swap contract.

*Demand Promissory Note.* On July 14, 2009, the Company executed a \$10.0 million secured demand promissory note in favor of a bank (the "Demand Note"). Pursuant to the terms and conditions of the Demand Note, the Company may borrow, on a revolving basis, up to the principal face amount of the note. Such borrowings, if any, will be secured on a pari passu basis with the New Credit Facilities and the 2016 Senior Notes. All principal and accrued interest under the Demand Note will be immediately due and payable upon the bank's written demand. Interest will be payable monthly and determined using a LIBOR-based rate, plus 2.0%. Although there were no amounts outstanding on December 31, 2011 and February 17, 2012, the effective interest rate on the Demand Note was approximately 2.6% and 2.5%, respectively, on those dates.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**2. Long-Term Debt (continued)**

**b. Senior Debt Securities**

*2020 Senior Notes.* On November 18, 2011, the Company completed a private placement of \$875.0 million in aggregate principal amount of 7.375% Senior Notes due 2020 (the "2020 Senior Notes") at an issue price of 100% to qualified institutional buyers under Rule 144A of the Securities Act of 1933 and to persons outside the United States in accordance with Regulation S thereunder. The Company used the net proceeds from this debt offering, together with the net proceeds from the term loans under the New Credit Facilities, to repay all amounts outstanding under the Predecessor Credit Facilities and the Knoxville Credit Agreement (as defined below).

The 2020 Senior Notes are senior unsecured debt obligations that bear interest at the rate of 7.375% per annum, payable semi-annually in arrears on January 15 and July 15 of each year, beginning on July 15, 2012. The 2020 Senior Notes mature on January 15, 2020 at which time the entire \$875.0 million of principal is due and payable. At any time on or after January 15, 2016, the 2020 Senior Notes are redeemable at the Company's option, in whole or in part, at the redemption prices set forth in the related indenture, plus accrued and unpaid interest. Prior to January 15, 2016, the Company may redeem the 2020 Senior Notes, in whole or in part, at a redemption price equal to 100% of the principal amount of the notes being redeemed, plus a "make-whole" premium and accrued and unpaid interest. Prior to January 15, 2015, the Company may also redeem up to 35% of the original principal amount of the 2020 Senior Notes with the proceeds from certain equity offerings at a redemption price of 107.375% of the principal amount of the notes being redeemed, plus accrued and unpaid interest.

Among other things, the indenture that governs the 2020 Senior Notes limits and restricts the ability of Health Management Associates, Inc. and certain of its subsidiaries to: (i) incur additional indebtedness; (ii) pay dividends or make other distributions or repurchase or redeem capital stock; (iii) prepay, redeem or repurchase certain debt; (iv) make loans and investments; (v) consolidate, merge or sell all or substantially all of their assets; (vi) incur liens; (vii) enter into transactions with affiliates; and (viii) enter into sale-leaseback transactions. Each of the aforementioned limitations and restrictions are subject to exceptions and qualifications. Upon the occurrence of a change of control, as defined in the indenture, each holder of a 2020 Senior Note will have the right to require the Company to repurchase all or a part of such holder's notes at a purchase price equal to 101% of the principal amount of the notes being repurchased, plus accrued and unpaid interest. Additionally, the Company may be required to use the proceeds from certain asset dispositions to repurchase 2020 Senior Notes at 100% of their principal amount, plus accrued and unpaid interest. The indenture governing the 2020 Senior Notes contains covenants, terms, events of default and related cure provisions that are customary in agreements used in connection with similar transactions.

The 2020 Senior Notes, although unsecured, are guaranteed on a joint and several basis by the same Company subsidiaries that are borrowers and/or guarantors under the New Credit Facilities and the 2016 Senior Notes (as defined below). The 2020 Senior Notes: (i) rank equally in right of payment with all of the Company's and its subsidiary guarantors' existing and future senior unsecured indebtedness; (ii) rank senior in right of payment to all of the Company's and its subsidiary guarantors' existing and future subordinated indebtedness; (iii) are effectively subordinated to all of the Company's and its subsidiary guarantors' existing and future secured indebtedness, to the extent of the value of the pledged assets; and (iv) are structurally subordinated to all of the existing and future liabilities of each of the Company's subsidiaries that do not guarantee the 2020 Senior Notes.

In connection with the sale of the 2020 Senior Notes, the Company entered into a Registration Rights Agreement, pursuant to which it will: (i) file a registration statement with the Securities and Exchange Commission with respect to a registered offer to exchange the 2020 Senior Notes for publicly registered notes of the Company (the "Exchange Notes") that will have terms substantially identical, in all material respects, to the 2020 Senior Notes and (ii) cause such registration statement to be declared effective on or before November 16, 2012. Upon the registration statement being declared effective, the Company will offer the Exchange Notes to holders of the 2020 Senior Notes in exchange for the surrender of their existing notes. In certain instances, the Company may also be required by the Registration Rights Agreement to file a shelf registration statement with the Securities and Exchange Commission for the resale of the 2020 Senior Notes. If the Company fails to meet its obligations under the Registration Rights Agreement, the interest rate on the 2020 Senior Notes will increase by 0.25% per annum for the first 90 day period following such failure and will increase by an additional 0.25% per annum for each subsequent 90 day period that the Company fails to meet its obligations, up to a maximum of 1.00% per annum.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**2. Long-Term Debt (continued)**

*2016 Senior Notes.* On April 21, 2006, the Company completed the sale of \$400.0 million of 6.125% Senior Notes due 2016 (the “2016 Senior Notes”). The 2016 Senior Notes (i) mature on April 15, 2016 at which time the entire \$400.0 million of principal is due and payable and (ii) bear interest at a fixed rate of 6.125% per annum, payable semi-annually in arrears on April 15 and October 15. As a result of the 2011 Debt Restructuring, the 2016 Senior Notes are secured on a pari passu basis with the New Credit Facilities and the Demand Note.

If any of the Company’s subsidiaries are required to issue a guaranty in favor of the lenders under any credit facility ranking equal with the 2016 Senior Notes, such subsidiaries are also required, under the terms of the 2016 Senior Notes, to issue a guaranty for the benefit of the holders of the 2016 Senior Notes on substantially the same terms and conditions. As a result of the 2011 Debt Restructuring and the guarantees provided thereunder, the Company’s material domestic wholly owned subsidiaries (other than certain exempted subsidiaries) have provided guarantees of payment to the holders of the 2016 Senior Notes on a basis similar to the guarantees provided under the New Credit Facilities.

In connection with the sale of the 2016 Senior Notes, the Company entered into an indenture that governs such notes. The 2016 Senior Notes (and such other debt securities that may be issued from time to time under the indenture) are subject to certain covenants, which include, among other things, limitations and restrictions on: (i) the incurrence of debt secured by liens against the Company and its subsidiaries; (ii) the incurrence of subsidiary debt; (iii) sale lease-back transactions; and (iv) certain consolidations, mergers and transfers of assets. Each of the aforementioned limitations and restrictions are subject to certain contractual exceptions. The indenture governing the 2016 Senior Notes contains covenants, terms, events of default and related cure provisions that are customary in agreements used in connection with similar transactions.

**c. Convertible Senior Subordinated Notes**

On May 21, 2008, the Company completed a private placement of \$250.0 million of its 3.75% Convertible Senior Subordinated Notes due 2028 (the “2028 Notes”) to qualified institutional buyers under Rule 144A of the Securities Act of 1933. The 2028 Notes are general unsecured obligations that are subordinated in right of payment to all of the Company’s existing and future senior indebtedness. The 2028 Notes mature on May 1, 2028 and bear interest at a fixed rate of 3.75% per annum, payable semi-annually in arrears on May 1 and November 1. The Company can redeem the 2028 Notes for cash at any time on or after May 1, 2014, in whole or in part, at a “Redemption Price” equal to 100% of the principal amount of the notes to be redeemed, plus accrued and unpaid interest. Holders of the 2028 Notes have the right to require the Company to repurchase some or all of their notes for cash at the Redemption Price on May 1, 2014, May 1, 2018 and May 1, 2023. If the Company undergoes a Fundamental Change (as defined in the indenture governing the 2028 Notes) at any time prior to May 1, 2014, holders of the 2028 Notes will have the right to require the Company to repurchase some or all of their notes for cash at the Redemption Price.

Upon the occurrence of certain events, which are described below, the 2028 Notes become convertible into cash and, in select situations, shares of the Company’s common stock at a predetermined conversion rate that is subject to mandatory adjustment in some circumstances. The 2028 Notes are convertible at the option of the holders at the applicable “Conversion Rate” on any day prior to the scheduled trading day immediately preceding November 1, 2027 under the following circumstances: (i) if during any fiscal quarter the last reported sales price of the Company’s common stock for at least twenty trading days during the period of thirty consecutive trading days ending on the last trading day of the previous fiscal quarter is greater than or equal to 130% of the “Conversion Price” per share of the Company’s common stock on each such trading day; (ii) if the Company calls the 2028 Notes for redemption; (iii) if during the five business-day period after any five consecutive trading day period (i.e., the measurement period) in which the trading price per note for each day of the measurement period is less than 98% of the product of the last reported sales price of the Company’s common stock and the applicable Conversion Rate on each such day; or (iv) upon the occurrence of specified transactions, including, among other things, certain distributions to the Company’s stockholders. The 2028 Notes are also convertible at the option of the noteholders at any time from November 1, 2027 through the third scheduled trading day immediately preceding their maturity date.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**2. Long-Term Debt (continued)**

Upon the issuance of the 2028 Notes, the Conversion Rate was initially set at 85.034 shares of the Company's common stock per \$1,000 principal amount of such notes. The corresponding Conversion Price was initially set at \$11.76 per share of the Company's common stock. Both the Conversion Rate and the Conversion Price are subject to mandatory adjustment upon the occurrence of certain events that are identified in the indenture governing the 2028 Notes. Noteholders are entitled to receive additional shares or cash upon the conversion of their notes if (i) the volume-weighted average price of the Company's common stock during an Observation Period (as defined in the indenture governing the 2028 Notes) is greater than the Conversion Price or (ii) certain Fundamental Changes occur prior to May 1, 2014. The indenture governing the 2028 Notes contains covenants, terms, events of default and related cure provisions that are customary in agreements used in connection with similar transactions.

During the year ended December 31, 2009, the Company used cash on hand to repurchase approximately \$108.6 million of principal face amount 2028 Notes. Such notes were repurchased in the open market at approximately 62.4% of their principal face amount, plus accrued and unpaid interest. In connection with such 2028 Note repurchases, the Company recorded a net gain on the early extinguishment of debt of \$16.2 million. Prior to 2009, the Company repurchased \$50.0 million of principal face amount 2028 Notes in the open market.

When the 2028 Notes were originally issued, the Company recorded a debt discount of approximately \$58.1 million and an after-tax increase to additional paid-in capital of \$34.0 million. The outstanding 2028 Notes at December 31, 2011 (principal face amount of \$91.4 million) were recorded net of debt discounts of \$9.8 million. The Company is amortizing the debt discount over a remaining period of 2.3 years using an effective interest rate of approximately 8.8%. The Company recorded interest expense of \$7.3 million, \$7.0 million and \$7.8 million on the 2028 Notes during the years ended December 31, 2011, 2010 and 2009, respectively.

**d. Acquisition-Related Borrowings**

On September 30, 2011, one of the Company's wholly owned subsidiaries, Knoxville HMA Holdings, LLC ("HMA Knoxville"), and certain subsidiaries of HMA Knoxville entered into a credit agreement with a syndicate of banks (the "Knoxville Credit Agreement"). HMA Knoxville entered into the Knoxville Credit Agreement to facilitate its September 30, 2011 acquisition of substantially all of the assets of seven general acute care hospitals and certain related ancillary health care operations in east Tennessee. See Note 4 for information regarding this acquisition. In connection with the 2011 Debt Restructuring, the Knoxville Credit Agreement was terminated on November 18, 2011 and (i) all of the principal and accrued interest outstanding thereunder was repaid and (ii) HMA Knoxville wrote-off deferred debt issuance costs, net of accumulated amortization, of approximately \$10.4 million. The Knoxville Credit Agreement consisted of a \$360.0 million term loan and a \$150.0 million revolving credit facility.

The full amount of the term loan was borrowed by HMA Knoxville on September 30, 2011 and that amount was included as part of the total cash consideration paid to complete the abovementioned acquisition. Borrowings under the revolving credit facility could only be used by HMA Knoxville for its working capital and general corporate purposes. The revolving credit facility allowed HMA Knoxville to borrow, on a revolving basis, up to an aggregate of \$150.0 million, as adjusted for outstanding standby letters of credit of up to \$5.0 million. HMA Knoxville borrowed approximately \$29.2 million under the revolving credit facility through November 18, 2011. Such amount was used to pay closing costs associated with the Knoxville Credit Agreement and provide start-up working capital to HMA Knoxville and its subsidiaries. HMA Knoxville could elect whether interest on the Knoxville Credit Agreement was calculated using LIBOR or prime as its base rate. The effective interest rate included a spread above the base rate selected by HMA Knoxville.

**Other.** The estimated fair values of the Company's long-term debt instruments, determined by reference to quoted market prices and/or bid and ask prices in the relevant market, are summarized in the table below (in thousands).

	<b>December 31,</b>	
	<b>2011</b>	<b>2010</b>
New Term Loan A	\$ 708,688	\$ -
New Term Loan B	1,393,000	-
Predecessor Term Loan	-	2,448,211
2016 Senior Notes	416,000	405,000
2020 Senior Notes	910,000	-
2028 Notes	94,391	109,543

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**2. Long-Term Debt (continued)**

The estimated fair values of the Company's other long-term debt instruments reasonably approximate their carrying amounts in the consolidated balance sheets. See Note 1(j) and Note 5 for discussion of the estimated fair values of the Company's other financial instruments, including valuation methods and significant assumptions.

At December 31, 2011, the Company was in compliance with all of the covenants contained in its debt agreements. Moreover, at such date, the Company had reserved a sufficient number of shares of its common stock to satisfy the potential conversion of some or all of the 2028 Notes.

Capitalized interest was approximately \$6.0 million, \$2.7 million and \$4.8 million during the years ended December 31, 2011, 2010 and 2009, respectively.

Scheduled maturities of long-term debt, exclusive of capital lease obligations, for the next five years ending December 31 and thereafter are summarized in the table below (in thousands).

2012	\$ 69,522
2013	69,546
2014	178,165
2015	122,967
2016	849,221
Thereafter	2,206,293
	<u>\$ 3,495,714</u>

For purposes of the above table, it was assumed that the 2028 Notes will be repurchased on May 1, 2014 because the noteholders can unilaterally exercise their contractual rights to require the Company to repurchase some or all of their notes on such date.

**3. Leases**

The Company leases real property, equipment and vehicles under cancelable and non-cancelable leases. Certain of the Company's lease agreements provide standard renewal options and recurring escalations of lease payments for, among other things, increases in the lessors' maintenance costs and taxes. Future minimum operating and capital lease payments for the next five years ending December 31 and thereafter, including amounts relating to leased hospitals, are summarized in the table below (in thousands).

	<u>Operating</u>			<u>Capital</u>	
	<u>Real Property</u>	<u>Real Property Master Leases</u>	<u>Equipment</u>	<u>Real Property and Equipment</u>	<u>Totals</u>
2012	\$ 37,545	\$ 19,252	\$ 68,848	\$ 22,722	\$ 148,367
2013	30,787	17,581	54,827	17,468	120,663
2014	25,755	13,731	37,153	15,934	92,573
2015	21,987	13,219	24,653	15,678	75,537
2016	19,210	11,251	9,009	12,013	51,483
Thereafter	67,539	39,171	4,940	95,417	207,067
Total minimum payments	<u>\$ 202,823</u>	<u>\$ 114,205</u>	<u>\$ 199,430</u>	179,232	<u>\$ 695,690</u>
Less amounts representing interest				(74,820)	
Present value of minimum lease payments				<u>\$ 104,412</u>	

The Company has entered into several real property master leases with unrelated entities in the ordinary course of business. These leases are for buildings on or near hospital properties that are either subleased to unrelated third parties or used by the local hospital in its daily operations. The Company also owns medical office buildings that are leased to unrelated third parties or used for internal purposes.

Including acquisition transactions, the Company entered into capital leases for real property and equipment of approximately \$63.3 million, \$12.6 million and \$3.0 million during the years ended December 31, 2011, 2010 and 2009, respectively. Amortization expense pertaining to property, plant and equipment under capital lease arrangements is included with depreciation and amortization expense in the consolidated statements of income.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**3. Leases (continued)**

The table below summarizes the Company's assets under capital lease arrangements and other assets that are directly related to the Company's leasing activities (e.g., leasehold improvements, contractual rights to operate hospitals, etc.), including a non-cash real property addition of approximately \$22.5 million at a Company hospital during the year ended December 31, 2010.

	December 31,	
	2011	2010
	(in thousands)	
Property, plant and equipment under capital lease arrangements and other capitalized assets relating to leasing activities	\$ 1,265,758	\$ 1,124,185
Accumulated depreciation and amortization	(572,111)	(522,432)
Net book value	<u>\$ 693,647</u>	<u>\$ 601,753</u>

**4. Acquisitions, Joint Ventures and Other Activity**

**Acquisition Activity.** The acquisitions described below, as well as the pending acquisition discussed at Note 15, are in furtherance of the part of the Company's business strategy that calls for the acquisition of hospitals and other ancillary health care businesses in non-urban communities. The Company's acquisitions are typically financed using a combination of available cash balances, proceeds from sales of available-for-sale securities, borrowings under revolving credit agreements and other long-term financing arrangements.

**2011 Acquisitions.** On September 30, 2011, a subsidiary of the Company, Knoxville HMA Holdings, LLC ("HMA Knoxville"), acquired from Catholic Health Partners and its subsidiary Mercy Health Partners, Inc. ("Mercy") substantially all of the assets of Mercy's seven general acute care hospitals in east Tennessee. Those hospitals are as follows:

- Mercy Medical Center St. Mary's in Knoxville (401 licensed beds);
- Mercy Medical Center North in Powell (108 licensed beds);
- Mercy Medical Center West in Knoxville (101 licensed beds);
- St. Mary's Jefferson Memorial Hospital in Jefferson City (58 licensed beds);
- St. Mary's Medical Center of Campbell County in LaFollette (66 licensed beds);
- St. Mary's Medical Center of Scott County in Oneida (25 licensed beds); and
- Baptist Hospital of Cocke County in Newport (74 licensed beds).

HMA Knoxville also acquired (i) substantially all of Mercy's ancillary health care operations that are affiliated with the aforementioned Tennessee-based hospitals (collectively those ancillary facilities are licensed to operate 74 beds) and (ii) Mercy's former Riverside hospital campus (which is licensed to operate 293 beds). The Company's east Tennessee hospital and health care network is now collectively referred to as Tennova Healthcare. See Note 10 for information regarding the Company's treatment of St. Mary's Medical Center of Scott County and the former Riverside hospital campus as discontinued operations on the date of acquisition. The total purchase price for this acquisition was approximately \$532.4 million in cash. Additionally, HMA Knoxville assumed certain long-term lease obligations and will make maintenance and capital expenditures at the acquired hospitals. This acquisition was financed with available cash balances, which included the proceeds from sales of available-for-sale securities, and bank financing, which is described at Note 2(d).

Effective May 1, 2011, one of the Company's subsidiaries acquired a 95% equity interest in a company that owns and operates Tri-Lakes Medical Center, a 112-bed general acute care hospital in Batesville, Mississippi, and certain related health care operations. The total purchase price for the Company's 95% equity interest was approximately \$38.8 million in cash. During the year ended December 31, 2011, certain of the Company's subsidiaries also acquired ten ancillary health care businesses for aggregate cash consideration of \$23.3 million.

**2010 Acquisitions.** Effective October 1, 2010, certain subsidiaries of the Company acquired from Wuesthoff Health Systems, Inc. the following general acute care hospitals and certain related health care operations: (i) 298-bed Wuesthoff Medical Center in Rockledge, Florida; and (ii) 115-bed Wuesthoff Medical Center in Melbourne, Florida. The total purchase price for this acquisition was approximately \$152.0 million in cash.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**4. Acquisitions, Joint Ventures and Other Activity (continued)**

Effective July 1, 2010, certain subsidiaries of the Company acquired from Shands HealthCare a 60% equity interest in each of the following general acute care hospitals and certain related health care operations: (i) 99-bed Shands Lake Shore hospital in Lake City, Florida; (ii) 15-bed Shands Live Oak hospital in Live Oak, Florida; and (iii) 25-bed Shands Starke hospital in Starke, Florida. Shands HealthCare or one of its affiliates continues to hold a 40% equity interest in each of these hospitals and any related health care operations. The total purchase price for the Company's 60% equity interests in these three hospitals was approximately \$21.5 million in cash. One of the Company's subsidiaries also entered into a lease extension for Shands Lake Shore hospital through June 30, 2040. Under the related operating agreements, Shands HealthCare may require the Company to purchase its 40% equity interest in one or more of the three abovementioned hospitals if the Company experiences a change of control. The purchase price in this regard would be set at the fair market value of the equity interests being acquired.

During the year ended December 31, 2010, certain subsidiaries of the Company also acquired six ancillary health care businesses, including one in which the Company held a pre-acquisition minority equity interest, through: (i) the issuance of subsidiary equity securities valued at approximately \$3.1 million; (ii) the payment of cash consideration of \$18.0 million; and (iii) the assumption of a capital lease agreement.

*2009 Acquisitions.* Effective December 1, 2009, certain subsidiaries of the Company acquired the Sparks Health System in Fort Smith, Arkansas, which included, among other things, a 492-bed general acute care hospital, physician practices and other related health care operations. The total purchase price for this acquisition was approximately \$138.2 million in cash. Additionally, effective September 30, 2009, a subsidiary of the Company issued equity securities valued at approximately \$9.2 million to acquire certain ancillary health care businesses.

*Other.* The Company's acquisitions are accounted for using the purchase method of accounting. The Company uses estimated exit price fair values as of the date of acquisition to (i) allocate the related purchase price to the assets acquired and liabilities assumed and (ii) record noncontrolling interests. Management uses a variety of techniques to estimate exit price fair values, including, but not limited to, valuation methodologies that derive fair values using a market approach based on comparable transactions and an approach based on depreciated replacement cost. The Company recorded incremental goodwill during each of the years ended December 31, 2011, 2010 and 2009 because the final negotiated purchase price in certain completed acquisitions exceeded the fair value of the net tangible and intangible assets acquired. Most of the goodwill that was added in 2011 and 2010 is expected to be tax deductible whereas the goodwill added in 2009 is generally non-deductible.

The Company incurred approximately \$5.0 million, \$0.9 million and \$0.3 million of acquisition-related costs that were included in other operating expenses in the consolidated statements of income during the years ended December 31, 2011, 2010 and 2009, respectively. Amounts paid for acquisition-related costs are included in net cash provided by continuing operating activities in the consolidated statements of cash flows.

The table below summarizes the purchase price allocations for the acquisitions that were completed during the three-year period ended December 31, 2011; however, in some cases, such purchase price allocations are preliminary and remain subject to future refinement as the Company gathers supplemental information.

	<b>Years Ended December 31,</b>		
	<b>2011</b>	<b>2010</b>	<b>2009</b>
		(in thousands)	
Assets acquired:			
Current and other assets	\$ 25,762	\$ 10,643	\$ -
Property, plant and equipment	499,900	190,364	139,645
Intangible and other long-term assets	59,606	-	-
Goodwill	89,910	27,305	7,733
Total assets acquired	<u>675,178</u>	<u>228,312</u>	<u>147,378</u>
Liabilities assumed:			
Current liabilities	(13,725)	(1,395)	-
Capital lease obligations and related other	(61,307)	(11,690)	-
Total liabilities assumed	<u>(75,032)</u>	<u>(13,085)</u>	<u>-</u>
Net assets acquired	<u>\$ 600,146</u>	<u>\$ 215,227</u>	<u>\$ 147,378</u>

During the three months ended December 31, 2011, the Company updated its acquisition accounting for the Mercy acquisition. Among other things, the Company recorded entries during that period to adjust the September 30, 2011 balances to (i) increase property, plant and equipment and other long-term liabilities by approximately \$33.6 million and \$19.2 million, respectively, and (ii) reduce goodwill by \$12.8 million.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**4. Acquisitions, Joint Ventures and Other Activity (continued)**

The intangible assets that were acquired during 2011 as part of the Company's acquisitions were primarily contractual rights to operate hospitals and other health care facilities (approximately \$43.9 million, including \$1.1 million allocated to discontinued operations) and non-compete arrangements (\$8.4 million). The Company amortizes those intangible assets on a straight-line basis with no residual value over the remaining terms of the related contracts. The weighted average future amortization periods for the intangible assets acquired during the year ended December 31, 2011 are 7.7 years and 4.8 years for the contractual operating rights and non-compete arrangements, respectively.

A rollforward of the Company's goodwill is summarized in the table below (in thousands).

	<b>Years Ended December 31,</b>	
	<b>2011</b>	<b>2010</b>
Balances at the beginning of the year	\$ 909,470	\$ 881,365
Current year acquisition activity	89,910	27,305
Adjustments for prior period acquisitions, including income tax matters, net	-	800
Balances at the end of the year	<u>\$ 999,380</u>	<u>\$ 909,470</u>

The operating results of entities acquired by the Company's subsidiaries are included in the Company's consolidated financial statements from the date of acquisition. If an acquired entity was subsequently sold, closed or is being held for sale, its operations are included in discontinued operations, which are discussed at Note 10.

The table below sets forth certain combined pro forma financial information as if the Mercy acquisition had closed on January 1, 2010 (in thousands, except per share data).

	<b>Years Ended December 31,</b>	
	<b>2011</b>	<b>2010</b>
Net revenue	\$ 6,294,419	\$ 5,708,518
Consolidated net income	207,518	174,679
Net income attributable to Health Management Associates, Inc.	182,303	152,500
Earnings per share attributable to Health Management Associates, Inc. common stockholders:		
Basic	\$ 0.72	\$ 0.61
Diluted	0.71	0.61

The 2011 pro forma amounts for net income and earnings per share in the above table have been adjusted to exclude approximately \$4.8 million of acquisition-related expenses for the abovementioned Mercy acquisition. However, there were no 2011 or 2010 pro forma adjustments made to reflect potential cost reductions or operating efficiencies. Accordingly, the combined pro forma financial information is for comparative purposes only and is not necessarily indicative of the results that the Company would have experienced if the Mercy acquisition had actually occurred on January 1, 2010 or that may occur in the future. During the three months ended December 31, 2011, the Mercy hospitals and their related health care entities (i.e., Tennova Healthcare) contributed \$152.5 million and \$4.0 million of net revenue to continuing operations and discontinued operations, respectively. During that same period, Tennova Healthcare's losses from continuing operations and discontinued operations were \$1.6 million and \$1.7 million, respectively. Included in Tennova Healthcare's other operating expenses from continuing operations during the three months ended December 31, 2011 was \$12.9 million of restructuring costs, consisting primarily of severance pay and related health and welfare benefits.

**Joint Ventures and Redeemable Equity Securities.** As of December 31, 2011, the Company had established joint ventures to own/lease and operate 28 of its hospitals. Local physicians and/or other health care entities own minority equity interests in each of the joint ventures and participate in the related hospital's governance. The Company owns a majority of the equity interests in each joint venture and manages the related hospital's day-to-day operations.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**4. Acquisitions, Joint Ventures and Other Activity (continued)**

*Novant Health, Inc.* Prior to January 1, 2009, Novant Health, Inc. and one or more of its affiliates (collectively, "Novant") acquired from the Company (i) a 27% equity interest in a limited liability company that then owned/leased and operated the Company's seven general acute care hospitals in North Carolina and South Carolina (the "Carolina Joint Venture") and (ii) certain property, plant and equipment of the physician practices that were affiliated with those hospitals. Novant also assumed full operational and fiscal responsibility for such physician practices; however, the Company was required to partially subsidize the related losses, if any, for a period of up to three years in an amount not to exceed \$4.0 million per annum (the "Physician Subsidy"). Effective October 1, 2009, the Carolina Joint Venture was restructured as described below, resulting in a gain of approximately \$10.4 million (\$0.03 per diluted share) that has been included in discontinued operations under gains (losses) on sales of assets and related other. The portion of the gain attributable to the remeasurement of the Company's retained interest in each of Franklin Regional Medical Center and Upstate Carolina Medical Center was nominal. The realized gain was determined after allocating \$14.3 million of goodwill to those hospitals.

- (i) all of the equity interests in Davis Regional Medical Center in Statesville, North Carolina, Sandhills Regional Medical Center in Hamlet, North Carolina, Carolina Pines Regional Medical Center in Hartsville, South Carolina and Chester Regional Medical Center in Chester, South Carolina were distributed from the Carolina Joint Venture to the Company;
- (ii) Franklin Regional Medical Center in Louisburg, North Carolina and Upstate Carolina Medical Center in Gaffney, South Carolina continue to be owned by the Carolina Joint Venture; however, Novant now manages both hospitals and receives 99% of the net profits, net losses, free cash flow and capital accounts of those hospitals (effectively reducing the Company's interest in each hospital from 73% to 1%);
- (iii) Lake Norman Regional Medical Center in Mooresville, North Carolina continues to be owned by the Carolina Joint Venture and managed by the Company (subject to certain management rights expressly delegated to Novant); however, Novant now receives 30% of the net profits, net losses, free cash flow and capital accounts of the hospital (effectively a 3% increase in Novant's interest in the hospital);
- (iv) the Company paid Novant approximately \$7.6 million, which included the purchase of certain assets used by physicians previously employed by Novant who returned to the Company's employment. Additionally, the Company agreed to make ten annual installment payments of \$200,000 to Novant, the first of which was in January 2010;
- (v) Novant may require the Company to purchase its 30% interest in Lake Norman Regional Medical Center for the greater of \$150.0 million or the fair market value of such interest in the hospital. This right is contingent on a change of control (excluding certain changes of control wherein the Company's senior executive management team is retained); and
- (vi) the Company's remaining Physician Subsidy obligation, if any, was cancelled.

As a result of the Carolina Joint Venture restructuring, Franklin Regional Medical Center and Upstate Carolina Medical Center have been included in discontinued operations (see Note 10).

*Redeemable Equity Securities and Other.* When completing a joint venture transaction, the Company subsidiary that is a party to the joint venture customarily issues equity securities that provide the noncontrolling shareholders with a unilateral right to require the Company's subsidiary to redeem such securities (typically at the lower of the original investment or fair market value). As recorded in the consolidated balance sheets, redeemable equity securities represent (i) the minimum amounts that can be unilaterally redeemed for cash by noncontrolling shareholders in respect of their subsidiary equity holdings and (ii) the initial unadjusted estimated fair values of certain contingent rights held by Novant and Shands HealthCare, which are described above. As of December 31, 2011 and through February 17, 2012, the mandatory redemptions requested by noncontrolling shareholders in respect of their subsidiary equity holdings have been nominal.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**4. Acquisitions, Joint Ventures and Other Activity (continued)**

A rollforward of the Company's redeemable equity securities is summarized in the table below (in thousands).

	Years Ended December 31,		
	2011	2010	2009
Balances at the beginning of the year	\$ 201,487	\$ 182,473	\$ 48,868
Noncontrolling shareholder interests in an acquired business	2,046	-	-
Investments by noncontrolling shareholders	-	5,679	65,063
Purchases of subsidiary shares from and distributions to noncontrolling shareholders	(2,890)	(1,032)	(29)
Estimated fair values of noncontrolling shareholders' contingent rights	-	14,367	68,571
Balances at the end of the year	<u>\$ 200,643</u>	<u>\$ 201,487</u>	<u>\$ 182,473</u>

Management believes it is not probable that the contingent rights of Novant and Shands HealthCare will vest because there are no circumstances known to management that would trigger the requisite change of control provision with either party. Accordingly, insofar as the contingent rights are concerned, the carrying values of the related redeemable equity securities have not been adjusted since being initially recorded.

The table below presents certain information regarding the changes in the ownership interests of Health Management Associates, Inc. in its consolidated subsidiaries as a result of the abovementioned 2009 joint venture activity (in thousands). No similar disclosures are required for the years ended December 31, 2011 and 2010.

Net income attributable to Health Management Associates, Inc.	\$ 138,182
Changes in the additional paid-in capital of Health Management Associates, Inc. due to:	
Sale of subsidiary shares to a noncontrolling shareholder	2,019
Purchase of subsidiary shares from a noncontrolling shareholder	(6,594)
Incremental costs of certain transactions with noncontrolling shareholders	(1,054)
Net transfers to a noncontrolling shareholder and related other	(5,629)
Change from net income attributable to Health Management Associates, Inc., net transfers to a noncontrolling shareholder and related other	<u>\$ 132,553</u>

**5. Fair Value Measurements, Available-For-Sale Securities and Restricted Funds**

**General.** GAAP defines fair value as the amount that would be received for an asset or paid to transfer a liability (i.e., an exit price) in the principal market for the asset or liability in an orderly transaction between market participants on the measurement date. GAAP also establishes a hierarchy that requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. GAAP describes the following three levels of inputs that may be used:

- Level 1: Quoted prices (unadjusted) in active markets that are accessible at the measurement date for identical assets and liabilities. The fair value hierarchy gives the highest priority to Level 1 inputs.
- Level 2: Observable prices that are based on inputs not quoted on active markets but corroborated by market data.
- Level 3: Unobservable inputs when there is little or no market data available, thereby requiring an entity to develop its own assumptions. The fair value hierarchy gives the lowest priority to Level 3 inputs.

Transfers between levels within the fair value hierarchy are recognized by the Company on the date of the change in circumstances that requires such transfer. The table below summarizes the estimated fair values of the Company's financial assets (liabilities) as of December 31, 2011 (in thousands).

	Level 1	Level 2	Level 3	Totals
Available-for-sale securities, including those in restricted funds	<u>\$ 216,535</u>	<u>\$ 30,275</u>	<u>\$ -</u>	<u>\$ 246,810</u>
Interest rate swap contract	<u>\$ -</u>	<u>\$ (162,307)</u>	<u>\$ -</u>	<u>\$ (162,307)</u>

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**5. Fair Value Measurements, Available-For-Sale Securities and Restricted Funds (continued)**

The estimated fair value of the Company's interest rate swap contract was determined using a model that considers various inputs and assumptions, including LIBOR swap rates, cash flow activity, forward yield curves and other relevant economic measures, all of which are observable market inputs that are classified under Level 2 of the fair value hierarchy. The model also incorporates valuation adjustments for credit risk. The table below summarizes the Company's balance sheet classification of the estimated fair values of its interest rate swap contract liabilities (in thousands).

	<b>December 31,</b>	
	<b>2011</b>	<b>2010</b>
Accrued expenses and other liabilities	\$ 86,975	\$ -
Other long-term liabilities	75,332	215,473
Totals	<u>\$ 162,307</u>	<u>\$ 215,473</u>

The Company's Level 2 available-for-sale securities primarily consist of bonds and notes issued by (i) the United States government and its agencies and (ii) domestic and foreign corporations. The estimated fair values of these securities are determined using various valuation techniques, including a multi-dimensional relational model that incorporates standard observable inputs and assumptions such as benchmark yields, reported trades, broker/dealer quotes, issuer spreads, benchmark securities, bids/offers and other pertinent reference data.

See Note 1(j) and Note 2 for discussion of the estimated fair values of the Company's other financial instruments, including valuation methods.

**Available-For-Sale Securities (including those in restricted funds).** Supplemental information regarding the Company's available-for-sale securities, which consisted of debt securities and shares in publicly traded stocks and mutual funds (all of which had no withdrawal restrictions), is set forth in the table below (in thousands).

	<b>Cost</b>	<b>Gross Unrealized Gains</b>	<b>Gross Unrealized Losses</b>	<b>Estimated Fair Values</b>
<b>As of December 31, 2011:</b>				
Debt securities and debt-based mutual funds				
Government	\$ 125,338	\$ 1,164	\$ (25)	\$ 126,477
Corporate	76,995	356	(708)	76,643
Equity securities and equity-based mutual funds				
Domestic	26,220	2,354	(431)	28,143
International	15,446	304	(1,288)	14,462
Commodity-based fund	1,533	-	(448)	1,085
Totals	<u>\$ 245,532</u>	<u>\$ 4,178</u>	<u>\$ (2,900)</u>	<u>\$ 246,810</u>
<b>As of December 31, 2010:</b>				
Debt-based mutual funds				
Government	\$ 120,026	\$ 326	\$ (308)	\$ 120,044
Corporate	6,943	457	-	7,400
Equity-based mutual funds				
Domestic	4,840	751	-	5,591
International	8,147	1,190	-	9,337
Totals	<u>\$ 139,956</u>	<u>\$ 2,724</u>	<u>\$ (308)</u>	<u>\$ 142,372</u>

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**5. Fair Value Measurements, Available-For-Sale Securities and Restricted Funds (continued)**

As of December 31, 2011 and 2010, investments with aggregate estimated fair values of approximately \$67.0 million (294 investments) and \$64.5 million (five investments), respectively, generated the gross unrealized losses disclosed in the table on the preceding page. Due to recent declines in the value of such securities and/or the Company's brief holding period (i.e., all such securities have been held for less than one year), as well as the Company's ability to hold the securities for a reasonable period of time sufficient for a projected recovery of fair value, management concluded that other-than-temporary impairment charges were not necessary at either of the balance sheet dates. Management will continue to monitor and evaluate the recoverability of the Company's available-for-sale securities.

As of December 31, 2011, the contractual maturities of debt securities held by the Company, excluding debt-based mutual fund holdings, are set forth in the table below. Expected maturities will differ from contractual maturities because the issuers of the debt securities may have the right to prepay their obligations without prepayment penalties.

	<b>Amortized Cost Basis</b>	<b>Estimated Fair Value</b>
	(in thousands)	
Within 1 year	\$ -	\$ -
After 1 year and through year 5	6,265	6,209
After 5 years and through year 10	9,036	9,044
After 10 years	14,762	15,022

Gross realized gains and losses on sales of available-for-sale securities and other investment income, which includes interest and dividends, are summarized in the table below (in thousands).

	<b>Years Ended December 31,</b>		
	<b>2011</b>	<b>2010</b>	<b>2009</b>
Realized gains	\$ 1,694	\$ 4,708	\$ 1,384
Realized losses	(1,176)	(380)	-
Investment income	6,962	7,132	2,832

**Restricted Funds.** The Company's restricted funds are held by a wholly owned captive insurance subsidiary that is domiciled in the Cayman Islands. The assets of such subsidiary are effectively limited to use in its proprietary operations. Restricted funds are primarily used to purchase reinsurance policies and pay professional liability indemnity losses and related loss expenses. The current and long-term classification of restricted funds is primarily based on the projected timing of professional liability claim payments. The table below summarizes the estimated fair values of the Company's restricted funds (in thousands).

	<b>December 31,</b>	
	<b>2011</b>	<b>2010</b>
Cash and cash equivalents	\$ -	\$ 5,706
Available-for-sale securities	124,533	85,045
Totals	<u>\$ 124,533</u>	<u>\$ 90,751</u>

Supplemental information regarding the available-for-sale securities that are included in restricted funds is set forth in the table below (in thousands).

	<b>Years Ended December 31,</b>		
	<b>2011</b>	<b>2010</b>	<b>2009</b>
Proceeds from sales	\$ 46,325	\$ 17,577	\$ 4,600
Purchases	86,057	18,981	72,117

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**6. Income Taxes**

The significant components of the Company's income tax expense (benefit) are summarized in the table below (in thousands).

	Years Ended December 31,		
	2011	2010	2009
Federal:			
Current	\$ 42,609	\$ 54,207	\$ (6,946)
Deferred	61,055	27,808	78,900
Total federal	<u>103,664</u>	<u>82,015</u>	<u>71,954</u>
State:			
Current	(15,697)	26,531	(584)
Deferred	18,104	(7,497)	11,567
Total state	<u>2,407</u>	<u>19,034</u>	<u>10,983</u>
Totals	<u>\$ 106,071</u>	<u>\$ 101,049</u>	<u>\$ 82,937</u>

Reconciliations of the federal statutory rate to the Company's effective income tax rates were as follows:

	Years Ended December 31,		
	2011	2010	2009
Federal statutory income tax rate	35.0%	35.0%	35.0%
State income taxes, net of federal benefit	0.5	4.3	2.9
Noncontrolling interests	(2.9)	(2.3)	(3.8)
Tax credits	-	(2.6)	(0.6)
Other	1.4	0.8	0.5
Totals	<u>34.0%</u>	<u>35.2%</u>	<u>34.0%</u>

Net income attributable to noncontrolling interests, which is not tax-effected in the consolidated financial statements, reduces the Company's effective income tax rates.

Tax-effected temporary differences that give rise to federal and state deferred income tax assets and liabilities are summarized in the table below (in thousands).

	December 31,	
	2011	2010
Deferred income tax assets:		
Interest rate swap contract	\$ 63,001	\$ 82,777
Accrued liabilities	50,001	41,551
Self-insured liabilities	41,843	31,186
State net operating loss and tax credit carryforwards	37,179	37,048
Other	27,788	29,669
Deferred income tax assets, before valuation allowances	<u>219,812</u>	<u>222,231</u>
Valuation allowances	<u>(22,981)</u>	<u>(16,989)</u>
Deferred income tax assets, net	<u>196,831</u>	<u>205,242</u>
Deferred income tax liabilities:		
Property, plant and equipment	(84,587)	(55,021)
Goodwill	(84,101)	(72,494)
Allowance for doubtful accounts	(40,119)	(23,925)
Joint ventures	(234,206)	(201,782)
Deferred gains on the early extinguishment of debt	(13,801)	(13,937)
Convertible debt discount amortization	(3,406)	(4,746)
Deferred revenue	(9,693)	(8,036)
Prepaid expenses	(11,464)	(9,530)
Deferred income tax liabilities	<u>(481,377)</u>	<u>(389,471)</u>
Net deferred income tax liabilities	<u>\$ (284,546)</u>	<u>\$ (184,229)</u>

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**6. Income Taxes (continued)**

Valuation allowances are the result of state net operating loss carryforwards that management believes may not be fully realized due to uncertainty regarding the Company's ability to generate sufficient future state taxable income. State net operating loss carryforwards aggregated approximately \$883 million at December 31, 2011 and have expiration dates through December 31, 2031.

A rollforward of the Company's unrecognized income tax benefits is presented below (in thousands).

	Years Ended December 31,		
	2011	2010	2009
Balances at the beginning of the year	\$ 36,129	\$ 34,910	\$ 28,520
Additions for tax positions of the current year	4,434	4,779	7,299
Additions for tax positions of prior years	9,209	3,407	1,736
Reductions for tax positions of prior years	(7,623)	(2,516)	-
Lapses of statutes of limitations	(6,164)	(4,084)	(2,156)
Settlements	(4,470)	(367)	(489)
Balances at the end of the year	<u>\$ 31,515</u>	<u>\$ 36,129</u>	<u>\$ 34,910</u>

Included in the Company's unrecognized income tax benefits at December 31, 2009 was approximately \$0.4 million of tax positions for which the ultimate deductibility is highly certain but for which there is uncertainty about the timing of such deductibility. Other than interest and penalties, the disallowance of those deductions in the short-term would not affect the Company's effective income tax rates but would accelerate payments to certain taxing authorities. There were no such unrecognized income tax benefits at December 31, 2011 and 2010.

The Company files numerous consolidated and separate federal and state income tax returns. With a few exceptions, there are no ongoing federal or state income tax examinations for periods before the year ended December 31, 2010. Management does not expect significant changes to the Company's income tax reserves over the next year due to current audits and/or potential statute extensions.

The Company recognizes interest and penalties related to unrecognized income tax benefits in its provision for income taxes. During the years ended December 31, 2010 and 2009, the Company recognized approximately \$1.8 million and \$1.1 million, respectively, of net interest and penalties expense. The Company recognized a corresponding net benefit of \$1.3 million during the year ended December 31, 2011 due to the reversal of certain previously established accrued expense balances. At December 31, 2011 and 2010, the Company had accrued \$7.6 million and \$8.9 million, respectively, for interest and penalties.

In the normal course of business, there may be differences between the Company's income tax provision for financial reporting purposes and final settlements with taxing authorities. These differences, which principally relate to state income tax matters, are subject to interpretation pursuant to the applicable regulations. Management does not believe that the resolution of these differences will have a material adverse effect on the Company's consolidated financial position, results of operations or cash flows.

**7. Earnings Per Share**

Basic earnings per share is computed based on the weighted average number of outstanding common shares. Diluted earnings per share is computed based on the weighted average number of outstanding common shares plus the dilutive effect of common stock equivalents, primarily computed using the treasury stock method.

GAAP requires contingently convertible debt instruments, if dilutive, to be included in diluted earnings per share calculations, regardless of whether or not the market price trigger contained in the convertible debt instrument was met. The 2028 Notes, which are discussed at Note 2(c), were structured so that the common stock underlying those securities are not immediately included in the diluted earnings per share calculations.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**7. Earnings Per Share (continued)**

The table below sets forth the computations of basic and diluted earnings (loss) per share for the common stockholders of Health Management Associates, Inc. (in thousands, except per share amounts).

	Years Ended December 31,		
	2011	2010	2009
<b>Numerators:</b>			
Income from continuing operations	\$ 206,334	\$ 185,774	\$ 161,303
Income attributable to noncontrolling interests	(25,215)	(22,179)	(24,981)
Income from continuing operations attributable to Health Management Associates, Inc. common stockholders	181,119	163,595	136,322
Income (loss) from discontinued operations	(2,409)	(13,526)	2,638
Income from discontinued operations attributable to noncontrolling interests	-	-	(778)
Income (loss) from discontinued operations attributable to Health Management Associates, Inc. common stockholders	(2,409)	(13,526)	1,860
Net income attributable to Health Management Associates, Inc. common stockholders	\$ 178,710	\$ 150,069	\$ 138,182
<b>Denominators:</b>			
Denominator for basic earnings (loss) per share-weighted average number of outstanding common shares	251,541	248,272	245,381
Dilutive securities: stock-based compensation arrangements	3,496	2,834	1,584
Denominator for diluted earnings (loss) per share	255,037	251,106	246,965
<b>Earnings (loss) per share:</b>			
<b>Basic</b>			
Continuing operations	\$ 0.72	\$ 0.66	\$ 0.55
Discontinued operations	(0.01)	(0.05)	0.01
Net income	\$ 0.71	\$ 0.61	\$ 0.56
<b>Diluted</b>			
Continuing operations	\$ 0.71	\$ 0.65	\$ 0.55
Discontinued operations	(0.01)	(0.05)	0.01
Net income	\$ 0.70	\$ 0.60	\$ 0.56
<b>Securities excluded from diluted earnings (loss) per share because they were antidilutive or performance conditions were not met:</b>			
Stock options	4,042	6,673	10,033
Deferred stock and restricted stock	605	682	1,979

**8. Stock-Based Compensation**

**Background.** The Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan (the "EICP") permits the Company to grant stock awards to: (i) employees; (ii) independent directors serving on the Company's Board of Directors; and (iii) non-employed physicians and clinicians who provide the Company with bona fide advisory or consulting services. The Company has granted non-qualified stock options and awarded other stock-based compensation to key employees and directors under the EICP or its predecessor plan; however, no stock awards have been granted to non-employed physicians and clinicians. The Health Management Associates, Inc. 2006 Outside Director Restricted Stock Award Plan (the "2006 Director Plan") provided for annual issuances of restricted stock awards to independent directors; however, only a nominal amount of shares remain available for award under such plan. Accordingly, beginning January 1, 2011, annual deferred stock awards have been granted to independent directors under the EICP.

The Company has approximately 43.4 million shares of common stock authorized for stock-based compensation under all of its plans (12.0 million shares remained available for award at December 31, 2011). The Company's policy is to issue new shares of common stock to satisfy stock option exercises and other stock-based compensation arrangements. If an award granted under a stock-based plan is forfeited, expires, terminates or is otherwise satisfied without delivery of shares of common stock to the plan participant, then the underlying shares will become available again for the benefit of employees, directors and non-employed physicians and clinicians.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**8. Stock-Based Compensation (continued)**

**General.** GAAP requires that the fair value of all share-based payments to employees and directors be measured on their grant date and either recognized as expense in the income statement over the requisite service period or, if appropriate, capitalized and amortized. Compensation expense for the stock-based arrangements described below, which is recorded in salaries and benefits in the consolidated statements of income, was approximately \$25.2 million, \$18.4 million and \$10.9 million during the years ended December 31, 2011, 2010 and 2009, respectively. Substantially all such expense relates to the Company's deferred stock and restricted stock awards. The Company has not capitalized any stock-based compensation amounts. For awards with service-only vesting conditions, stock-based compensation expense is recognized on a straight-line basis over the requisite service period, which is generally aligned with the underlying stock-based award's vesting period. If an award has either a performance or market vesting condition, stock-based compensation expense is recognized ratably from the service inception date to the vesting date for each tranche of the award. For stock-based arrangements with performance conditions as a prerequisite to vesting, compensation expense is not recognized until it is probable that the corresponding performance condition will be achieved. During the years ended December 31, 2011, 2010 and 2009, stock-based compensation expense yielded income tax benefits of \$9.7 million, \$7.1 million and \$3.9 million, respectively, that have been recognized in the consolidated statements of income.

Cash receipts from all stock-based plans during the years ended December 31, 2011, 2010, and 2009 were approximately \$14.1 million, \$7.5 million and \$9.7 million, respectively. Realized income tax benefits, including those pertaining to deferred stock and restricted stock awards for which the Company receives no cash proceeds upon issuance of the underlying common stock, were \$11.0 million, \$4.8 million and \$3.0 million during the years ended December 31, 2011, 2010 and 2009, respectively.

**Deferred Stock and Restricted Stock Awards.** Deferred stock is a right to receive shares of common stock upon fulfillment of specified conditions. Historically, the Company's only deferred stock vesting condition has been continuous employment; however, a component of the 2011 and 2010 deferred stock awards to certain key managers also included a performance criterion based on the Company's operating results. The Company provides deferred stock to its key employees through stock incentive awards that generally vest 20% to 25% per annum or 100% on the fourth grant anniversary date. At the completion of the vesting period, common stock is issued to the grantee.

Restricted stock represents shares of common stock that preserve the indicia of ownership for the holder but are subject to restrictions on transfer and risk of forfeiture until fulfillment of specified conditions. In addition to requiring continuous service as an employee, the annual vesting of senior executive officer restricted stock awards requires the satisfaction of certain predetermined performance objectives that are set by the Compensation Committee of the Board of Directors. The independent directors' restricted stock awards and deferred stock awards under the 2006 Director Plan and the EICP, respectively, vest in four equal installments on January 1 of each year following the grant date, provided that the recipient remains an independent director on such dates or certain other conditions are met.

On March 11, 2008, the Compensation Committee approved and implemented a long-term incentive compensation program for certain senior executive officers (the "LTI Program"), which provides long-term incentive compensation in the form of cash payments and equity awards. Annual targeted incentive compensation awards under the LTI Program are expected to be granted as follows: (i) restricted stock that vests based on service; (ii) restricted stock that vests based on the satisfaction of performance criteria; and (iii) cash based on the satisfaction of the same performance criteria. The predetermined performance criterion that will be reviewed annually for vesting purposes is currently an operational fiscal measure of the Company that is defined in the grant award. Full vesting of awards under the LTI Program also requires continuous employment with the Company over a four-year period, with awards vesting 25% per annum. Based on the service and performance criteria under the LTI Program, approximately 715,000 shares of restricted stock vested after December 31, 2011.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**8. Stock-Based Compensation (continued)**

Deferred stock and restricted stock activity for the Company's stock-based compensation plans, inclusive of participants employed at discontinued operations, is summarized in the table below.

	Shares		Weighted Average Grant Date Fair Values	
	Deferred Stock	Restricted Stock	Deferred Stock	Restricted Stock
	(in thousands)			
Balances at January 1, 2009 (non-vested)	5,008	569	\$ 7.02	\$ 6.25
Granted	135	1,317	5.64	1.76
Vested	(1,792)	(104)	6.46	7.34
Forfeited	(368)	(32)	7.71	5.27
Balances at December 31, 2009 (non-vested)	2,983	1,750	7.03	2.83
Granted	4,544	824	7.39	7.33
Vested	(879)	(480)	7.25	3.31
Forfeited	(432)	-	7.16	-
Balances at December 31, 2010 (non-vested)	6,216	2,094	7.25	4.45
Granted	4,139	505	9.63	9.67
Vested	(1,992)	(653)	7.67	4.33
Forfeited	(1,334)	-	7.95	-
Balances at December 31, 2011 (non-vested)	7,029	1,946	8.38	5.89

Subsequent to December 31, 2011, approximately 2.4 million shares of deferred stock vested upon completion of the requisite service and attainment of the 2011 performance criterion. The Company also granted new restricted stock awards and deferred stock awards to senior executive officers, key managers and independent directors. Underlying those awards were 7.6 million shares of the Company's common stock that will vest 25% per annum if the individual remains an independent director or employee of the Company, subject to, in some circumstances, the satisfactory achievement of the 2012 LTI Program performance criterion.

The aggregate intrinsic values of deferred stock and restricted stock issued during the years ended December 31, 2011, 2010 and 2009 were approximately \$25.6 million, \$10.1 million and \$5.6 million, respectively. The aggregate grant date fair values of deferred stock and restricted stock awards that vested during such years were \$18.1 million, \$8.0 million and \$12.3 million, respectively.

Compensation expense for deferred stock and restricted stock awards is based on the fair value (i.e., market price) of the underlying stock on the date of grant, except for awards with a market condition (i.e., awards that require the attainment of certain predetermined market prices of the Company's common stock as a vesting requirement). For awards with market conditions, management uses valuation methodologies to estimate their fair values. Because such awards have not been used by the Company in recent years, they had a nominal financial impact on the Company's consolidated operating results during the years presented herein. At December 31, 2011, there was approximately \$40.5 million of unrecognized compensation cost attributable to non-vested deferred stock and restricted stock awards. Such cost is expected to be recognized over the remaining requisite service period for each award, the weighted average of which is approximately 2.8 years.

**Stock Options.** All employee stock options have ten year terms and vest 25% on each grant anniversary date over four years of continuous employment with the Company. Stock options granted to the independent members of the Company's Board of Directors have ten year terms and vest 25% on each grant anniversary date, provided that such individual remains an independent director on the vesting dates.

Stock-based compensation expense for stock options is based on the estimated fair values of the stock option awards on the date of grant as determined by the Black-Scholes option pricing model. At December 31, 2011, there was approximately \$0.1 million of unrecognized compensation cost attributable to a non-vested employee stock option award that is expected to be recognized over the award's remaining requisite service period of approximately 0.7 years. The aggregate grant date fair value of stock options that vested during each of the years ended December 31, 2011, 2010 and 2009 was \$0.2 million. The aggregate intrinsic values of stock options exercised during the years ended December 31, 2011, 2010 and 2009 were \$2.8 million, \$2.2 million and \$2.6 million, respectively.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**8. Stock-Based Compensation (continued)**

Stock option activity for the Company's stock-based compensation plans, inclusive of participants employed at discontinued operations, is summarized in the table below.

	Options (in thousands)	Weighted Average Exercise Prices	Weighted Average Remaining Contractual Terms (Years)	Aggregate Intrinsic Values (in thousands)
Outstanding at January 1, 2009	12,977	\$ 8.48		
Exercised	(1,632)	5.94		
Terminated	(2,795)	7.29		
Outstanding at December 31, 2009	8,550	9.38		
Exercised	(1,094)	6.82		
Terminated	(281)	10.20		
Outstanding at December 31, 2010	7,175	9.74		
Exercised	(1,563)	9.00		
Terminated	(610)	10.59		
Outstanding at December 31, 2011 (all are expected to vest)	5,002	\$ 9.87	2.20	\$ 1,310
Exercisable options at December 31, 2011	4,877	\$ 10.01	2.10	\$ 983

Except for 125,000 stock options with an exercise price of \$4.75, all of the Company's outstanding stock options at December 31, 2011 in the table below are currently exercisable.

Exercise Price	Number Outstanding (in thousands)	Weighted Average Remaining Contractual Terms (Years)
\$ 4.75	500	6.7
9.22	1,177	1.4
9.91	948	0.4
11.31	2,377	2.4

**9. Retirement Plans**

The Company maintains defined contribution retirement plans that cover substantially all of its employees. Under those plans, the Company can elect to match a portion of employee contributions. During the period from January 1, 2009 through September 30, 2010, substantially all matching contributions were suspended. The total retirement plan matching contribution expense during the years ended December 31, 2011, 2010 and 2009 was approximately \$9.2 million, \$2.9 million and \$1.2 million, respectively.

Additionally, the Company maintains a supplemental retirement plan for certain executive officers. Generally, that plan provides for annual payments after the attainment of normal retirement age (62) or early retirement age (55) in the case of one participant, if the individuals are still employed by the Company on those dates. Supplemental retirement plan payments generally continue for the remainder of the executive officer's life.

**10. Discontinued Operations**

The Company's discontinued operations during the years presented herein included: (i) the 172-bed Woman's Center at Dallas Regional Medical Center in Mesquite, Texas; (ii) 189-bed Gulf Coast Medical Center in Biloxi, Mississippi; (iii) 140-bed Riley Hospital in Meridian, Mississippi; (iv) 25-bed Fishermen's Hospital in Marathon, Florida; (v) 70-bed Franklin Regional Medical Center in Louisburg, North Carolina; (vi) 125-bed Upstate Carolina Medical Center in Gaffney, South Carolina; (vii) 25-bed St. Mary's Medical Center of Scott County in Oneida, Tennessee; (viii) a 293-bed idle hospital campus in Knoxville, Tennessee; and (ix) certain other health care operations affiliated with those hospitals. Note 4 discusses the Company's divestiture of Franklin Regional Medical Center and Upstate Carolina Medical Center.

The operating results and cash flows of discontinued operations are included in the Company's consolidated financial statements up to the date of disposition. Additionally, as required by GAAP, the operating results and cash flows of the abovementioned entities have been separately presented as discontinued operations in the Company's consolidated financial statements. Because Fishermen's Hospital became a discontinued operation subsequent to December 31, 2010, the Company's 2010 and 2009 consolidated financial statements have been retroactively adjusted in accordance with GAAP to conform to the current year presentation.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**10. Discontinued Operations (continued)**

The Company closed Gulf Coast Medical Center ("GCMC") on January 1, 2008. On July 18, 2011, the remaining real property at GCMC was sold for cash consideration of approximately \$3.4 million, less selling and other related costs. The resulting gain of \$0.6 million has been included in discontinued operations during the year ended December 31, 2011. During the years ended December 31, 2010 and 2009, the Company recorded long-lived asset impairment charges in respect of GCMC of \$8.4 million and \$2.2 million, respectively, to reduce the hospital's assets to their estimated net realizable value.

During May 2011, one of the Company's subsidiaries entered into a lease termination agreement for Fishermen's Hospital that became effective on July 1, 2011. As part of the agreement, the hospital's remaining equipment, as well as certain working capital items, were sold to the Company's former lessor for \$1.5 million in cash. The Fishermen's Hospital lease termination resulted in a goodwill impairment charge of \$3.6 million during the year ended December 31, 2011. Management decided not to renegotiate a new lease agreement for Fishermen's Hospital, in large part, because recent operating results and future projections were below expectations.

On December 31, 2010, certain of the Company's subsidiaries sold Riley Hospital and its related health care operations (collectively, "Riley Hospital"), which included the hospital's supplies and long-lived assets (primarily property, plant and equipment). The selling price, which was paid in cash, was \$24.0 million, plus a working capital adjustment. After allocating approximately \$5.9 million of goodwill to the hospital, this divestiture resulted in a loss of \$12.1 million during the year ended December 31, 2010. During the year ended December 31, 2011, discontinued operations included a post-closing working capital purchase price adjustment for Riley Hospital of \$0.3 million that increased the Company's loss on the sale of such hospital.

The Woman's Center at Dallas Regional Medical Center (the "Woman's Center") was closed on June 1, 2008. Although management is currently evaluating various disposal alternatives for this idle facility, the timing of such divestiture has not yet been determined. Management concluded that the estimated fair value of the hospital's long-lived assets, less costs to sell, was lower than the corresponding net book value of such assets. Accordingly, the Company recorded a long-lived asset impairment charge of approximately \$2.4 million during the year ended December 31, 2009 to reduce the hospital's long-lived assets to their estimated net realizable value.

As discussed at Note 4, a subsidiary of the Company acquired St. Mary's Medical Center of Scott County ("SMMC") and the idle Riverside hospital campus ("Riverside") from Mercy on September 30, 2011. The aggregate allocated purchase price for SMMC and Riverside was approximately \$12.4 million and has been included in investing activities under discontinued operations in the Company's consolidated statements of cash flows. SMMC is a leased facility with a lease agreement that expires in May 2012. For the same reason discussed above in respect of Fishermen's Hospital, management does not intend to extend or otherwise modify the SMMC lease. Mercy closed the hospital at the Riverside location prior to the Company's acquisition of the facility. Although management is currently evaluating various disposal alternatives for each of SMMC and Riverside, the timing of such divestitures has not yet been determined.

The table below sets forth the underlying details of the Company's discontinued operations (in thousands).

	Years Ended December 31,		
	2011	2010	2009
Net revenue	\$ 17,615	\$ 76,845	\$ 151,236
Salaries and benefits	6,854	29,742	58,515
Provision for doubtful accounts	3,430	9,958	29,635
Depreciation and amortization	1,624	6,600	10,291
Other operating expenses	6,331	32,105	54,790
Long-lived asset and goodwill impairment charges	3,614	8,410	4,550
(Gains) losses on sales of assets and related other, net (see Note 4)	(304)	12,113	(10,428)
	<u>21,549</u>	<u>98,928</u>	<u>147,353</u>
Income (loss) before income taxes	(3,934)	(22,083)	3,883
Income tax benefit (expense)	1,525	8,557	(1,245)
Income (loss) from discontinued operations	<u>\$ (2,409)</u>	<u>\$ (13,526)</u>	<u>\$ 2,638</u>

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**10. Discontinued Operations (continued)**

The table below summarizes the principal components of the Company's assets of discontinued operations (in thousands).

	<b>December 31,</b>	
	<b>2011</b>	<b>2010</b>
Supplies, prepaid expenses and other assets	\$ 569	\$ 1,082
Property, plant and equipment, net, and other	13,992	6,688
Goodwill	-	3,614
Total assets of discontinued operations	<u>\$ 14,561</u>	<u>\$ 11,384</u>

**11. Accumulated Other Comprehensive Income (Loss)**

GAAP defines comprehensive income as the change in equity of a business enterprise from transactions and other events and circumstances that relate to non-owner sources. A rollforward of the Company's accumulated other comprehensive income (loss) is presented in the table below (in thousands).

	<b>Unrealized Gains (Losses) on Available-for-Sale Securities</b>	<b>Interest Rate Swap Contract</b>	<b>Totals</b>
Balances at January 1, 2009, net of income taxes of \$113,836	\$ -	\$ (169,914)	\$ (169,914)
Unrealized gains (losses) on available-for-sale securities, net of income taxes of \$735	1,351	-	1,351
Change in fair value of interest rate swap contract, net of income taxes of \$37,602	-	48,321	48,321
Balances at December 31, 2009, net of income taxes of \$75,499	1,351	(121,593)	(120,242)
Unrealized gains (losses) on available-for-sale securities, net of income taxes of \$859	1,614	-	1,614
Adjustments for net (gains) losses reclassified into net income, net of income taxes of \$750	(1,393)	-	(1,393)
Change in fair value of interest rate swap contract, net of income taxes of \$6,543	-	(11,103)	(11,103)
Balances at December 31, 2010, net of income taxes of \$81,933	1,572	(132,696)	(131,124)
Unrealized gains (losses) on available-for-sale securities, net of income taxes of \$39	(78)	-	(78)
Adjustments for net (gains) losses reclassified into net income, net of income taxes of \$357	(663)	-	(663)
Change in fair value of interest rate swap contract, net of income taxes of \$17,662	-	30,073	30,073
Reclassification adjustments for amortization of expense into net income, net of income taxes of \$4,032	-	6,352	6,352
Balances at December 31, 2011, net of income taxes of \$60,635	<u>\$ 831</u>	<u>\$ (96,271)</u>	<u>\$ (95,440)</u>

Prior to the Company's debt restructuring on November 18, 2011, which is discussed at Note 2, the Company's interest rate swap contract had been a perfectly effective cash flow hedge instrument that was used to manage the risk of variable interest rate fluctuation on certain long-term debt. Changes in its estimated fair value were previously recognized as a component of other comprehensive income (loss). See Note 2(a) and Note 5 for further discussion of the interest rate swap contract. As a result of the Company's debt restructuring, the interest rate swap contract is no longer an effective cash flow hedge instrument. Therefore, subsequent changes in its estimated fair value are no longer included in other comprehensive income (loss) but are recognized in the Company's consolidated statements of income as interest expense. Future amortization of the accumulated other comprehensive loss attributable to the interest rate swap contract is expected to approximate \$79.0 million, \$70.3 million and \$8.1 million during the years ending December 31, 2012, 2013 and 2014, respectively.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**12. Recent Accounting Standards Updates**

During August 2010, the Financial Accounting Standards Board (the "FASB") approved a change to certain accounting standards. That change prohibits health care entities from netting projected insurance recoveries against the related liabilities and/or reserves in their balance sheets (e.g., professional liability claims and expenses, workers' compensation, health and welfare benefits, etc.). The modified accounting standard, which permitted early adoption, was required to be adopted for fiscal years and interim periods that began after December 15, 2010. Additionally, such accounting standard permitted adoption on either a prospective or retrospective basis. Effective January 1, 2011, the Company adopted the modified accounting standard on a prospective basis. The only impact of such adoption was an increase of approximately \$15.4 million in the Company's deferred charges and other assets and a corresponding increase in the related liabilities. That "gross-up" amount was \$15.9 million at December 31, 2011. Management does not believe that retrospective application of the modified accounting standard to any period prior to January 1, 2011 would have resulted in a material change to any of the Company's historical interim or annual consolidated financial statements.

During May 2011, the FASB amended and updated the accounting standards in GAAP as they relate to fair value measurement (the "Fair Value Update"). The Fair Value Update (i) expands and enhances GAAP's current disclosures about fair value measurements and (ii) clarifies the FASB's intent about the application of existing fair value measurement requirements in certain circumstances. Public companies were required to adopt the provisions of the Fair Value Update on a prospective basis during interim and annual periods that began after December 15, 2011. Early adoption of the amended accounting guidance was not permitted. There was no material impact from the Company's adoption of the Fair Value Update on January 1, 2012.

During June 2011, the FASB amended and updated the accounting standards in GAAP regarding the presentation of comprehensive income (the "OCI Update"). Among other things, the OCI Update (i) eliminated the option to report total comprehensive income and its components in the statement of changes in stockholders' equity and (ii) required the presentation of net income/loss, items of other comprehensive income and total comprehensive income in one continuous financial statement or two separate but consecutive financial statements. The OCI Update did not change the accounting for any items of other comprehensive income. Public companies were required to adopt the provisions of the OCI Update on a retrospective basis during interim and annual periods beginning after December 15, 2011. Early adoption of the OCI Update was permitted. The Company adopted the OCI Update, which only affects the presentation of the consolidated financial statements, during the year ended December 31, 2011.

During July 2011, the FASB amended and updated the accounting standards in GAAP regarding the income statement presentation and related disclosures of net revenue for health care entities (the "Net Revenue Update"). Among other things, the Net Revenue Update requires health care entities to (i) present the provision for doubtful accounts as a reduction of net patient service revenue in the income statement if the entity does not assess a patient's ability to pay prior to rendering services or determine that collection of the related revenue is reasonably assured and (ii) provide enhanced disclosures about major sources of revenue by payor and the activity in the allowance for doubtful accounts. The Net Revenue Update does not otherwise change the revenue recognition criteria for health care entities. Public companies were required to adopt the provisions of the Net Revenue Update during interim and annual periods beginning after December 15, 2011. The income statement presentation change must be adopted on a retrospective basis but the enhanced disclosures may be adopted either retrospectively or prospectively. Early adoption of the Net Revenue Update was permitted. The Net Revenue Update, which only affects the presentation of the consolidated income statement and certain related disclosures, was adopted by the Company on January 1, 2012. The required changes will be reflected in the interim condensed consolidated financial statements to be included in the Company's Quarterly Report on Form 10-Q for the three months ending March 31, 2012.

**13. Commitments and Contingencies**

**Renovation and Expansion Projects.** As of December 31, 2011, the Company had started: (i) construction of a 250-bed general acute care hospital to ultimately replace the south campus facility at its Poplar Bluff Regional Medical Center in Poplar Bluff, Missouri; (ii) several hospital renovation and expansion projects; and (iii) various information technology hardware and software upgrades. Additionally, management estimates that the remaining cost to build and equip a replacement hospital for Walton Regional Medical Center in Monroe, Georgia will range from \$20 million to \$25 million. The Company is currently obligated to complete construction of this replacement hospital no later than December 31, 2012. Management does not believe that any of the Company's construction, renovation and/or expansion projects are individually significant or that they represent, in the aggregate, a material commitment of the Company's resources.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**13. Commitments and Contingencies (continued)**

**Standby Letters of Credit.** At December 31, 2011, the Company maintained approximately \$104.4 million of standby letters of credit in favor of third parties with various expiration dates through February 21, 2013; however, such amount was reduced to \$54.1 million on February 17, 2012. The December 31, 2011 balance reflected a transitional period after completion of the 2011 Debt Restructuring.

**Physician and Physician Group Guarantees.** The Company is committed to providing financial assistance to physicians and physician groups practicing in the communities that its hospitals serve through certain recruiting arrangements and professional services agreements. At December 31, 2011, the Company was committed to non-cancelable guarantees of approximately \$73.0 million under such arrangements. The actual amounts advanced will depend on the financial results of each physician's and physician group's private practice during the related contractual measurement period, which generally approximates one to two years. Amounts advanced under these agreements are considered to be loans. Provided that the physician or physician group continues to practice in the community served by the Company's hospital, the loan is generally forgiven on a pro rata basis over a period of 12 to 24 months. Management believes that the recorded liabilities for physician and physician group guarantees of \$30.2 million and \$10.3 million at December 31, 2011 and 2010, respectively, are adequate and reasonable; however, there can be no assurances that the ultimate liability will not exceed management's estimates. Estimated guarantee liabilities and the related intangible assets are predicated on historical payment patterns and an evaluation of the facts and circumstances germane to the specific contract under review. If the costs of these arrangements exceed management's estimates, the liabilities could materially increase.

**Professional Liability Risks.** The Company uses its wholly owned captive insurance subsidiary and its risk retention group subsidiary, which are domiciled in the Cayman Islands and South Carolina, respectively, to self-insure a significant portion of its professional liability risks. Those subsidiaries, which are collectively referred to as the "Insurance Subsidiaries," provide (i) claims-made coverage to all of the Company's hospitals and other health care facilities and (ii) occurrence-basis coverage to most of the Company's employed physicians. The employed physicians not covered by the Insurance Subsidiaries generally maintain claims-made policies with unrelated third party insurance companies. To mitigate the exposure of the program covering the Company's hospitals and other health care facilities, the Insurance Subsidiaries buy claims-made reinsurance policies from unrelated third parties for claims above certain self-retention levels.

The Company's discounted reserves for indemnity losses and related loss expenses, net of amounts estimated to be recoverable under reinsurance policies, were approximately \$215.6 million and \$180.9 million at December 31, 2011 and 2010, respectively. Such amounts were derived using a discount rate of 1.00% and a weighted average payment duration of approximately three years. A 50 basis point reduction in the discount rate during the year ended December 31, 2010, which was reflective of changes in market conditions, increased the Company's net reserves by \$2.4 million at December 31, 2010. See Note 12 for a change in GAAP that affected the Company's balance sheet presentation of its discounted reserves for indemnity losses and related loss expenses. The Company's undiscounted reserves for professional liability risks, net of amounts estimated to be recoverable under reinsurance policies, were \$221.4 million and \$185.8 million at December 31, 2011 and 2010, respectively. The Company included \$40.4 million and \$53.4 million in accrued expenses and other liabilities in the consolidated balance sheets at December 31, 2011 and 2010, respectively, to reflect the estimated loss and loss expense payments that are projected to be satisfied within one year of those balance sheet dates. The Company recorded total expenses for its professional liability risks of \$66.3 million, \$68.6 million and \$60.5 million during the years ended December 31, 2011, 2010 and 2009, respectively. Such expenses, which include indemnity losses, related loss expenses, interest accretion on discounted reserves and cumulative adjustments for changes in the discount rate, were determined using actuarially-based techniques and methodologies and have been included in other operating expenses in the Company's consolidated statements of income.

Considerable subjectivity, variability and judgment are inherent in professional liability risk estimates. Although management believes that the amounts included in the Company's consolidated financial statements are adequate and reasonable, there can be no assurances that the ultimate liability for professional liability matters will not exceed management's estimates. If actual indemnity losses and loss expenses exceed management's projections of claim activity and/or the projected claim payment duration differs from management's estimates, the Company's reserves could be materially adversely affected. Additionally, there can be no assurances that the reinsurance policies procured by the Insurance Subsidiaries will be adequate for the Company's professional liability profile.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**13. Commitments and Contingencies (continued)**

**Ascension Health Lawsuit.** On February 14, 2006, Health Management Associates, Inc. (referred to as "Health Management" for the remainder of this Note 13) announced the termination of non-binding negotiations with Ascension Health ("Ascension") and the withdrawal of a non-binding offer to acquire Ascension's St. Joseph Hospital, a general acute care hospital in Augusta, Georgia. On June 8, 2007, certain Ascension subsidiaries filed a lawsuit against Health Management, entitled *St. Joseph Hospital, Augusta, Georgia, Inc. et al. v. Health Management Associates, Inc.*, in Georgia Superior/State Court of Richmond County claiming that Health Management (i) breached an agreement to purchase St. Joseph Hospital and (ii) violated a confidentiality agreement. The plaintiffs claim at least \$40 million in damages. Health Management removed the case to the U.S. District Court for the Southern District of Georgia, Augusta Division (No. 1:07-CV-00104). On July 13, 2010, the plaintiffs filed a motion for partial summary judgment and Health Management filed a motion for summary judgment. On March 30, 2011, Health Management's motion for summary judgment was granted as to all of plaintiffs' claims, except for the breach of confidentiality claim, and plaintiffs' motion for partial summary judgment was denied. On June 15, 2011, the case was stayed pending resolution of the appellate process. On July 8, 2011, the plaintiffs filed a notice of appeal to the United States Court of Appeals for the Eleventh Circuit (Case Number: 11-13069). Oral argument is scheduled for the week of April 30, 2012.

Management does not believe there was a binding acquisition contract with Ascension or any of its subsidiaries and does not believe Health Management breached a confidentiality agreement. Accordingly, management will continue to vigorously defend Health Management against the allegations, including the pending appeal. Management does not believe that the final outcome of this matter will be material.

**Medicare Billing Lawsuit.** On January 11, 2010, Health Management and one of its subsidiaries were named in a qui tam lawsuit entitled *United States of America ex rel. J. Michael Mastey v. Health Management Associates, Inc. et al.* in the U.S. District Court for the Middle District of Florida, Tampa Division. The plaintiff's complaint alleged that, among other things, the defendants erroneously submitted claims to Medicare and that those claims were falsely certified to be in compliance with Section 1877 of the Social Security Act of 1935 (commonly known as the "Stark law") and the Anti-Kickback Statute. The plaintiff's complaint further alleged that the defendants' conduct violated the federal False Claims Act of 1863 (the "False Claims Act"). The plaintiff seeks recovery of all Medicare and Medicaid reimbursement that the defendants received as a result of the alleged false certifications and treble damages under the False Claims Act, as well as a civil penalty for each Medicare and Medicaid claim supported by such alleged false certifications. On August 18, 2010, the plaintiff filed a first amended complaint that was similar to the original complaint. On September 27, 2010, the defendants moved to dismiss the first amended complaint for failure to state a claim with the particularity required by Rule 9(b) of the Federal Rules of Civil Procedure and failure to state a claim upon which relief can be granted pursuant to Rule 12(b)(6) of those federal rules. On November 11, 2010, the plaintiff filed a memorandum of law in opposition to the defendants' motion to dismiss. On February 23, 2011, the case was transferred to the U.S. District Court for the Middle District of Florida, Fort Myers Division (No. 2:11-cv-00089-JES-DNF). On May 5, 2011, the plaintiff filed a second amended complaint, which was similar to the first amended complaint. On May 17, 2011, the defendants moved to dismiss the second amended complaint on the same bases set forth in their earlier motion to dismiss. On February 16, 2012, the court granted the defendants' motion to dismiss, without prejudice. The court's order permits the plaintiff to file an amended complaint within 21 days. If the plaintiff amends the complaint, management will vigorously defend Health Management and its subsidiary against the allegations. Management does not believe that the final outcome of this matter will be material.

**Governmental Matters.** Several Health Management hospitals received letters during the second half of 2009 requesting information in connection with a U.S. Department of Justice ("DOJ") investigation relating to kyphoplasty procedures. Kyphoplasty is a minimally invasive spinal procedure used to treat vertebral compression fractures. The DOJ is currently investigating hospitals and hospital operators in multiple states to determine whether certain Medicare claims for kyphoplasty were incorrect when billed as an inpatient service rather than as an outpatient service. Management believes that the DOJ's investigation originated with a False Claims Act lawsuit against Kyphon, Inc., the company that developed the kyphoplasty procedure. The requested information has been provided to the DOJ and management is cooperating with the investigation. To date, the DOJ has not asserted any monetary or other claims against the Health Management hospitals in this matter. Based on the aggregate billings for inpatient kyphoplasty procedures during the period under review that were performed at the Health Management hospitals subject to the DOJ's inquiry, management does not believe that the final outcome of this matter will be material.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**13. Commitments and Contingencies (continued)**

During September 2010, Health Management received a letter from the DOJ indicating that an investigation was being conducted to determine whether certain Health Management hospitals improperly submitted claims for the implantation of implantable cardioverter defibrillators ("ICDs"). The DOJ's investigation covers the period commencing with Medicare's expansion of coverage for ICDs in 2003 to the present. The letter from the DOJ further indicates that the claims submitted by Health Management's hospitals for ICDs and related services need to be reviewed to determine if Medicare coverage and payment was appropriate. During 2010, the DOJ sent similar letters and other requests to a large number of unrelated hospitals and hospital operators across the country as part of a nation-wide review of ICD billing under the Medicare program. Management has, and will continue to, cooperate with the DOJ in its ongoing investigation, which could potentially give rise to claims against Health Management and/or certain of its subsidiary hospitals under the False Claims Act or other statutes, regulations or laws. Additionally, management recently commenced an internal review of hospital medical records related to ICDs that are the subject of the DOJ investigation. To date, the DOJ has not asserted any monetary or other claims against Health Management or its hospitals in this matter and, at this time, management is unable to determine the potential impact, if any, that will result from the final resolution of the investigation.

The U.S. Department of Health and Human Services, Office of Inspector General ("HHS-OIG") and the DOJ, including the Civil Division and U.S. Attorney's Offices in the Eastern District of Pennsylvania, the Middle District of Florida, the Eastern District of Oklahoma, the Middle District of Tennessee, the Western District of North Carolina, the District of South Carolina and the Middle District of Georgia, are currently investigating Health Management and certain of its subsidiaries (HHS-OIG and the DOJ are collectively referred to as "Government Representatives"). Management believes that such investigations relate to the Anti-Kickback Statute, the Stark law and the False Claims Act and are focused on: (i) physician referrals, including financial arrangements with Health Management's whole-hospital physician joint ventures; (ii) the medical necessity of emergency room tests and patient admissions, including whether Pro-Med software has led to any medically unnecessary tests or admissions; and (iii) the medical necessity of certain surgical procedures. Management further believes that the investigations may have originated as a result of qui tam lawsuits filed on behalf of the United States. In connection with the investigations, HHS-OIG served subpoenas on Health Management on May 16, 2011 and July 21, 2011 requesting records. Additionally, Government Representatives have interviewed both current and former employees of Health Management and its subsidiaries. Health Management is conducting internal investigations and has met with Government Representatives on numerous occasions to respond to their inquiries. Management believes that the HHS-OIG subpoenas, which apply system-wide, may have been served pursuant to the authority of HHS-OIG to investigate health care fraud.

On February 22, 2012 and February 24, 2012, HHS-OIG served subpoenas on certain Health Management hospitals relating to those hospitals' relationships with Allegiance Health Management, Inc. ("Allegiance"). Allegiance, which is unrelated to Health Management, is a post acute health care management company that provides intensive outpatient psychiatric ("IOP") services to patients. The Health Management hospitals that were served subpoenas were: (i) Central Mississippi Medical Center in Jackson, Mississippi; (ii) Crossgates River Oaks Hospital in Brandon, Mississippi; (iii) Davis Regional Medical Center in Statesville, North Carolina; (iv) Lake Norman Regional Medical Center in Mooresville, North Carolina; (v) the Medical Center of Southeastern Oklahoma in Durant, Oklahoma; and (vi) Natchez Community Hospital in Natchez, Mississippi. Each of those hospitals has or had a contract with Allegiance. Among other things, the subpoenas seek: (i) documents related to the hospitals' financial relationships with Allegiance; (ii) documents related to patients who received IOP services from Allegiance at the Health Management hospitals, including their patient medical records; (iii) documents relating to complaints or concerns regarding Allegiance's IOP services at the Health Management hospitals; (iv) documents relating to employees, physicians and therapists who were involved in the provision of IOP services provided by Allegiance at the Health Management hospitals; and (v) other documents related to Allegiance including leases, contracts, policies and procedures, training documents, budgets and financial analyses. The period of time covered by the subpoenas is January 1, 2008 through the date of subpoena compliance. Management believes that HHS-OIG has served similar subpoenas on other non-Health Management hospitals that had contracts with Allegiance. Management intends to comply with the investigations. At this time, management is unable to determine the potential impact, if any, that will result from the final resolution of these investigations.

In addition to the abovementioned subpoenas and investigations, certain Health Management hospitals have received other requests for information from state and federal agencies. Management is cooperating with all of the ongoing investigations by collecting and producing the requested materials. Because a large portion of the abovementioned government investigations are in their early stages, management is unable to evaluate the outcome of such matters or determine the potential impact, if any, that could result from their final resolution.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**13. Commitments and Contingencies (continued)**

**Class Action Lawsuits.** On or about January 25, 2012, Health Management, certain of its executive officers and one of its directors were named as defendants in an action entitled *Miklen Sapssov v. Health Management Associates, Inc. et al.*, which was filed in the U. S. District Court for the Middle District of Florida (No. 2:12-CV-00046). This action purports to be brought on behalf of stockholders who purchased Health Management's common stock during the period July 27, 2009 through January 9, 2012. The plaintiff alleges, among other things, that Health Management and the other defendants violated Section 10(b) of the Securities Exchange Act of 1934 by making allegedly false and misleading statements in certain public disclosures regarding Health Management's business and financial results. The plaintiff alleges that Health Management's financial performance was based, in part, on improper billing practices. The plaintiff seeks unspecified damages. A substantially similar purported class action lawsuit, entitled *Norfolk County Retirement System v. Health Management Associates, Inc., et al.*, was filed against the same defendants on or about February 2, 2012 in the U. S. District Court for the Middle District of Florida (No. 8:12-CV-00228). Management intends to vigorously defend Health Management against the allegations in these matters. Because the abovementioned lawsuits are in their early stages, management is unable to evaluate their outcome or determine the potential impact, if any, that could result from their final resolution.

**Other.** The Company is also a party to various other legal actions arising out of the normal course of its business. Due to the inherent uncertainties of litigation and dispute resolution, management is unable to estimate the ultimate losses, if any, relating to each of the Company's outstanding legal actions and other loss contingencies. Should an unfavorable outcome occur in some or all of its legal and other related matters, there could be a material adverse effect on the Company's financial position, results of operations and liquidity.

**14. Quarterly Data (unaudited)**

The tables below summarize certain unaudited financial information for each of the quarters in the two-year period ended December 31, 2011.

	Quarters During the Year Ended December 31, 2011 (1)			
	First	Second (2)	Third (3)	Fourth (4)
	(in thousands, except per share amounts)			
Net revenue	\$ 1,426,829	\$ 1,395,353	\$ 1,398,495	\$ 1,583,774
Income from continuing operations	61,966	56,916	49,704	37,748
Income (loss) from discontinued operations	146	(1,583)	255	(1,227)
Consolidated net income	62,112	55,333	49,959	36,521
Net income attributable to Health Management Associates, Inc.	55,524	48,611	43,728	30,847
Earnings (loss) per share attributable to Health Management Associates, Inc. common stockholders:				
Basic				
Continuing operations	\$ 0.22	\$ 0.20	\$ 0.17	\$ 0.13
Discontinued operations	-	(0.01)	-	-
Net income	<u>\$ 0.22</u>	<u>\$ 0.19</u>	<u>\$ 0.17</u>	<u>\$ 0.13</u>
Diluted				
Continuing operations (5)	\$ 0.22	\$ 0.20	\$ 0.17	\$ 0.13
Discontinued operations	-	(0.01)	-	-
Net income (5)	<u>\$ 0.22</u>	<u>\$ 0.19</u>	<u>\$ 0.17</u>	<u>\$ 0.13</u>
Weighted average number of shares outstanding:				
Basic	250,038	251,765	252,157	252,175
Diluted	253,727	255,235	255,124	256,032

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (continued)**

**14. Quarterly Data (unaudited) (continued)**

	Quarters During the Year Ended December 31, 2010 (1)			
	First	Second	Third	Fourth (6)
	(in thousands, except per share amounts)			
Net revenue	\$ 1,265,154	\$ 1,230,101	\$ 1,250,362	\$ 1,346,549
Income from continuing operations	53,488	46,068	40,006	46,212
Income (loss) from discontinued operations	(69)	(355)	(126)	(12,976)
Consolidated net income	53,419	45,713	39,880	33,236
Net income attributable to Health Management Associates, Inc.	46,940	39,657	35,293	28,179
Earnings (loss) per share attributable to Health Management Associates, Inc. common stockholders:				
Basic				
Continuing operations	\$ 0.19	\$ 0.16	\$ 0.14	\$ 0.17
Discontinued operations	-	-	-	(0.05)
Net income	<u>\$ 0.19</u>	<u>\$ 0.16</u>	<u>\$ 0.14</u>	<u>\$ 0.12</u>
Diluted				
Continuing operations	\$ 0.19	\$ 0.16	\$ 0.14	\$ 0.16
Discontinued operations	-	-	-	(0.05)
Net income	<u>\$ 0.19</u>	<u>\$ 0.16</u>	<u>\$ 0.14</u>	<u>\$ 0.11</u>
Weighted average number of shares outstanding:				
Basic	247,555	248,390	248,526	248,600
Diluted	249,867	251,198	250,972	252,372

- (1) Net revenue, income from continuing operations and income (loss) from discontinued operations have been reclassified for all quarters to conform to the current year consolidated statement of income presentation. Such reclassifications primarily related to discontinued operations, which are discussed at Note 10.
- (2) As more fully discussed at Note 10, the loss from discontinued operations during the quarter ended June 30, 2011 included a goodwill impairment charge of approximately \$3.6 million.
- (3) During the quarter ended September 30, 2011, the Company recorded approximately \$9.3 million of costs for acquisitions and government investigations. See Notes 4 and 13 for discussion of these matters.
- (4) As more fully discussed at Note 2, the Company restructured its long-term debt on November 18, 2011. As a result, the quarter ended December 31, 2011 includes (i) approximately \$24.6 million of write-offs of deferred debt issuance costs and related other and (ii) \$16.4 million of accumulated other comprehensive loss amortization and net fair value adjustment expense that is attributable to the Company's interest rate swap contract. During such quarter, the Company also: (i) recognized \$38.2 million of benefit from the meaningful use measurement standard under various Medicare and Medicaid Healthcare Information Technology ("HCIT") incentive programs and (ii) recorded \$12.9 million of expense attributable to restructuring activities at Tennova Healthcare (see Note 4).
- (5) Due to rounding, the sum of the four quarters does not agree to the total for the year ended December 31, 2011.
- (6) As more fully discussed at Note 10, the loss from discontinued operations during the quarter ended December 31, 2010 included (i) a loss of approximately \$12.1 million on the sale of Riley Hospital and its related health care operations and (ii) a long-lived asset impairment charge of \$8.4 million.

**15. Subsequent Event**

On February 3, 2012, one of the Company's subsidiaries signed a definitive agreement with a subsidiary of INTEGRIS Health, Inc. ("INTEGRIS") to acquire an 80% equity interest in each of five Oklahoma-based general acute care hospitals and certain related health care operations. A subsidiary of INTEGRIS will retain a 20% equity interest in such entities. The hospitals to be acquired are as follows:

- Blackwell Regional Hospital in Blackwell (53 licensed beds);
- Clinton Regional Hospital in Clinton (64 licensed beds);
- Marshall County Medical Center in Madill (25 licensed beds);
- Mayes County Medical Center in Pryor (52 licensed beds); and
- Seminole Medical Center in Seminole (32 licensed beds).

Pursuant to the definitive acquisition agreement, the total purchase price for the 80% equity interests in these five hospitals will be \$60.0 million in cash. Additionally, the Company's subsidiary will assume certain long-term lease obligations. The acquired assets and assumed liabilities will include, among other things, supply inventories, property, plant and equipment and certain long-term lease obligations. Subject to regulatory approvals and other conditions customary to closing, management anticipates that this acquisition will close during the quarter ending June 30, 2012.

The abovementioned acquisition is in furtherance of that part of the Company's business strategy that calls for the acquisition of hospitals and other ancillary health care businesses in non-urban communities. Management plans to fund this acquisition with available cash balances and proceeds from sales of available-for-sale securities.

**Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure.**

Not applicable.

**Item 9A. Controls and Procedures.**

**Conclusion Regarding the Effectiveness of Disclosure Controls and Procedures**

Our President and Chief Executive Officer (principal executive officer) and our Executive Vice President and Chief Financial Officer (principal financial officer) evaluated our disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) as of the end of the period covered by this Form 10-K. Based on this evaluation, our President and Chief Executive Officer and our Executive Vice President and Chief Financial Officer concluded that our disclosure controls and procedures were effective as of such date.

**Changes in Internal Control Over Financial Reporting**

There has been no change in our internal control over financial reporting that occurred during the fourth quarter of the fiscal year covered by this Form 10-K that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

**Management's Annual Report on Internal Control Over Financial Reporting**

Our management is responsible for establishing and maintaining effective internal control over financial reporting, as such term is defined in Exchange Act Rule 13a-15(f). Our internal control system was designed under the supervision of our President and Chief Executive Officer and our Executive Vice President and Chief Financial Officer and with the participation of management in order to provide reasonable assurance regarding the reliability of our financial reporting and our preparation of financial statements for external purposes in accordance with U.S. generally accepted accounting principles.

All internal control systems, no matter how well designed and tested, have inherent limitations, including, among other things, the possibility of human error, circumvention or disregard. Therefore, even those systems of internal control that have been determined to be effective can provide only reasonable assurance that the objectives of the control system are met and may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Under the supervision of our President and Chief Executive Officer and our Executive Vice President and Chief Financial Officer and with the participation of management, we conducted an assessment of the effectiveness of our internal control over financial reporting based on the criteria set forth in "Internal Control-Integrated Framework" issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on an assessment of such criteria, management concluded that, as of December 31, 2011, we maintained effective internal control over financial reporting.

As more fully described under the heading "Acquisition Activity – 2011 Acquisitions" at Note 4 to the Consolidated Financial Statements in Item 8, we acquired seven general acute care hospitals and other ancillary health care operations from Catholic Health Partners and its subsidiary Mercy Health Partners, Inc. on September 30, 2011. The acquired facilities are now known collectively as "Tennova Healthcare." We excluded Tennova Healthcare from our 2011 assessment of the effectiveness of our internal control over financial reporting. Tennova Healthcare accounted for approximately \$630.0 million of our total assets at December 31, 2011 and \$152.5 million and \$4.0 million of our net revenue from continuing operations and discontinued operations, respectively, during the year then ended. We expect that our internal control system will be fully implemented at Tennova Healthcare during 2012 and correspondingly evaluated by us for effectiveness.

An assessment of the effectiveness of our internal control over financial reporting as of December 31, 2011 has been performed by Ernst & Young LLP, an independent registered public accounting firm. The attestation report of Ernst & Young LLP is included on the following page.

## **Attestation Report of the Independent Registered Public Accounting Firm**

### **REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM**

Board of Directors and Stockholders  
Health Management Associates, Inc.

We have audited Health Management Associates, Inc.'s internal control over financial reporting as of December 31, 2011 based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO criteria). Health Management Associates, Inc.'s management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Annual Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

As indicated in the accompanying Management's Annual Report on Internal Control Over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Tennova Healthcare, which are included in the 2011 consolidated financial statements of Health Management Associates, Inc. and constituted approximately \$630.0 million and \$521.3 million of total and net assets, respectively, as of December 31, 2011 and \$152.5 million and \$4.0 million of net revenue from continuing operations and discontinued operations, respectively, during the year then ended. Our audit of internal control over financial reporting of Health Management Associates, Inc. also did not include an evaluation of the internal control over financial reporting of Tennova Healthcare.

In our opinion, Health Management Associates, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2011, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Health Management Associates, Inc. as of December 31, 2011 and 2010, and the related consolidated statements of income, comprehensive income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2011 of Health Management Associates, Inc. and our report dated February 27, 2012 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Certified Public Accountants  
Miami, Florida  
February 27, 2012

#### **Item 9B. Other Information.**

Not applicable.

### **PART III**

#### **Item 10. Directors, Executive Officers and Corporate Governance.**

Except as set forth below, the information required by this Item 10 is incorporated into this Form 10-K by reference from our proxy statement to be issued in connection with our Annual Meeting of Stockholders to be held on May 22, 2012 under the headings "Election of Directors," "Corporate Governance" and "Section 16(a) Beneficial Ownership Reporting Compliance," which proxy statement will be filed not later than 120 days after December 31, 2011.

#### **Executive Officers**

Below is information regarding those persons who served as our executive officers during the year ended December 31, 2011, as well as Kerrin E. Gillespie and Linda A. Epstein, who became executive officers effective January 1, 2012 and January 7, 2012, respectively.

Gary D. Newsome, age 54, became our President and Chief Executive Officer and a director on September 13, 2008. From early 1998 until September 12, 2008, Mr. Newsome was employed by Community Health Systems, Inc. ("Community"). He started at Community as a Group Vice President and by the end of his tenure with the company he was a Division President with responsibility for hospitals in Illinois, New Jersey, Pennsylvania, Tennessee and West Virginia. Mr. Newsome previously held management positions with us from June 1993 to March 1998, including Divisional Vice President, Assistant Vice President/Operations and Group Operations Vice President. Mr. Newsome is a member of the American College of Healthcare Executives. Mr. Newsome received a Bachelor of Science degree from Bluefield State College in West Virginia and a Masters in Business Administration from Butler University in Indianapolis.

Kelly E. Curry, age 57, has served as our Executive Vice President since July 1, 2007 and, effective January 12, 2010, he also became our Chief Financial Officer. Mr. Curry also served as our Chief Administrative Officer from September 13, 2008 until January 12, 2010 and Chief Operating Officer from July 1, 2007 until September 12, 2008. Before such time, he served as a consultant to us on hospital operations from October 2006 to June 2007. Mr. Curry, who is a Certified Public Accountant, previously held management positions with us from March 1982 to October 1994, including the position of Chief Financial Officer from April 1987 to October 1994. Since 1995, Mr. Curry has served as Chairman and President of Foundation in Christ Ministries, Ltd. in Ireland. Mr. Curry also serves on the board of the United States affiliate of Grain of Wheat International and its Swiss-based parent charity corporation.

Robert E. Farnham, age 56, has served as our Senior Vice President - Finance since March 2001. From March 2001 until January 12, 2010, Mr. Farnham also served as our Chief Financial Officer. He joined us in 1985 and previously served as our Senior Vice President and Controller. Prior to joining us, Mr. Farnham, who is a Certified Public Accountant, was employed by the accounting firm of PricewaterhouseCoopers LLP, formerly known as Coopers & Lybrand LLP.

Timothy R. Parry, age 57, served as our Senior Vice President, General Counsel and Corporate Secretary during 2011 and through January 5, 2012, at which time he resigned as our General Counsel and Corporate Secretary. Additionally, effective March 2, 2012, he will retire. Mr. Parry joined us in February 1996 as our Vice President and Assistant General Counsel after twelve years with the law firm of Harter Secrest & Emery LLP, the last seven years as a partner. Mr. Parry became our General Counsel in 1997. Prior to joining Harter Secrest & Emery LLP, he was an Ohio Assistant Attorney General for two years and a law clerk for the U.S. District Court for the Southern District of Ohio. Mr. Parry is an adjunct professor of law at Ave Maria Law School in Naples, Florida and he was appointed to the school's faculty during 2009. He also previously served as a member of the Board of the Federation of American Hospitals.

Joseph C. Meek, age 56, has served as our Vice President and Treasurer since July 9, 2007. Prior to joining us, Mr. Meek held corporate treasury and investor relations positions of increasing responsibility with SSM Health Care, Spectrum Brands and Peabody Energy, all in St. Louis, Missouri, between 1998 and 2007. Mr. Meek also held banking positions with Industrial Bank of Japan, Yasuda Trust and Union Bank of Switzerland, all in Chicago, Illinois, between 1984 and 1998. On December 5, 2011, the Corporate Governance and Nominating Committee of our Board of Directors determined that Mr. Meek would no longer be considered an executive officer of our company; however, he continues to serve as our Vice President and Treasurer.

Kerrin ("Kerry") E. Gillespie, age 53, has served as our Executive Vice President of Operations Finance since January 1, 2012. Mr. Gillespie also served as our Senior Vice President and Divisional Chief Financial Officer from May 23, 2011 to December 31, 2011. From March 2010 until May 2011, he served as Senior Vice President and Chief Financial Officer of Radiation Therapy Services Holdings, Inc. Before joining Radiation Therapy Services Holdings, Inc., Mr. Gillespie served as Chief Financial Officer of Ardent Health Services, LLC from March

2007 to March 2010. During the period from April 1998 to February 2007, Mr. Gillespie was Vice President of Group Operations at Community Health Systems, Inc. Mr. Gillespie previously held financial and operational positions with us from June 1991 to April 1998, including Assistant Corporate Controller, Manager of Operations Finance and executive officer positions at certain of our hospitals. Mr. Gillespie, who is a Certified Public Accountant, is a member of the American Institute of Certified Public Accountants and the Financial Executives Institute, as well as a fellow of the Healthcare Financial Management Association.

Linda A. Epstein, age 52, has served as our acting General Counsel since January 7, 2012. She has also served as our Vice President and Associate General Counsel of Litigation and Risk Management since July 29, 2008. Prior to joining us, Ms. Epstein was a partner at the law firm of Wicker, Smith, O'Hara, McCoy & Ford, P.A., from May 2000 to July 2008, other than the period from May 2002 to September 2003 when she was a partner at the law firm of Ennis, Paige & Epstein, P.A. In addition to a law degree, Ms. Epstein also has a Bachelors in Science and Nursing degree. Ms. Epstein is currently a member of the Florida Bar Association, Collier County Bar Association, and American Health Lawyers Association.

### Code of Ethics

We have adopted a Code of Business Conduct and Ethics that applies to our principal executive officer, principal financial officer, principal accounting officer or controller or persons performing similar functions. Our Code of Business Conduct and Ethics also applies to all of our other employees and, as set forth therein, to our directors. On February 20, 2012, the Audit Committee of our Board of Directors amended the Code of Business Conduct and Ethics. None of the revised or expanded provisions represents a material change to our existing standards, policies or practices. Rather, the changes and enhancements were designed to both incorporate the principles of our "Getting to Great" initiative and provide additional formal guidance regarding the ethical behavior that we expect from our directors, officers and all of our other employees. The amended Code of Business Conduct and Ethics also incorporates and references certain of our internal resources that are designed to enhance adherence by such persons to the highest ethical standards and further support compliance with all applicable laws.

Our Code of Business Conduct and Ethics is posted on our website at [www.hma.com](http://www.hma.com) under Investor Relations. We intend to satisfy any disclosure requirements pursuant to Item 5.05 of Form 8-K regarding any amendment to, or a waiver from, certain provisions of our Code of Business Conduct and Ethics by posting such information on our website under Investor Relations.

### Item 11. Executive Compensation.

The information required by this Item 11 is incorporated into this Form 10-K by reference from our proxy statement to be issued in connection with our Annual Meeting of Stockholders to be held on May 22, 2012 under the headings "Executive Compensation" and "Compensation Committee Interlocks and Insider Participation," which proxy statement will be filed not later than 120 days after December 31, 2011.

### Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

Except as set forth below, the information required by this Item 12 is incorporated into this Form 10-K by reference from our proxy statement to be issued in connection with our Annual Meeting of Stockholders to be held on May 22, 2012 under the heading "Security Ownership of Certain Beneficial Owners and Management," which proxy statement will be filed not later than 120 days after December 31, 2011.

#### Securities Authorized for Issuance under Equity Compensation Plans as of December 31, 2011

Equity Compensation Plan Information			
Plan category	Number of securities to be issued upon exercise of outstanding options, warrants and rights	Weighted-average exercise price of outstanding options, warrants and rights	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a))
	(a)	(b)	(c)
Equity compensation plans approved by security holders <sup>(1)</sup>	12,031,482	\$ 4.10	12,015,626
Equity compensation plans not approved by security holders	-	-	-
Totals	<u>12,031,482</u>	<u>\$ 4.10</u>	<u>12,015,626</u>

(1) Includes, among other things, deferred stock awards granted to independent directors, officers and management staff pursuant to the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan. See Note 8 to the Consolidated Financial Statements in Item 8 of Part II for more information about our stock-based compensation plans.

**Item 13. Certain Relationships and Related Transactions, and Director Independence.**

The information required by this Item 13 is incorporated into this Form 10-K by reference from our proxy statement to be issued in connection with our Annual Meeting of Stockholders to be held on May 22, 2012 under the headings "Certain Transactions" and "Corporate Governance," which proxy statement will be filed not later than 120 days after December 31, 2011.

**Item 14. Principal Accountant Fees and Services.**

The information required by this Item 14 is incorporated into this Form 10-K by reference from our proxy statement to be issued in connection with our Annual Meeting of Stockholders to be held on May 22, 2012 under the heading "Selection of Independent Registered Public Accounting Firm," which proxy statement will be filed not later than 120 days after December 31, 2011.

**PART IV****Item 15. Exhibits, Financial Statement Schedules.**

We filed our consolidated financial statements in Item 8 of Part II. Additionally, the financial statement schedule entitled "Schedule II - Valuation and Qualifying Accounts" is filed as part of this Form 10-K under this Item 15.

All other schedules have been omitted since the required information is not present or is not present in amounts sufficient to require submission of the schedule or because the information required is included in the consolidated financial statements and notes thereto.

The exhibits filed as part of this Form 10-K are listed in the Index to Exhibits immediately following the signature page of this Form 10-K.

**HEALTH MANAGEMENT ASSOCIATES, INC.**  
**SCHEDULE II - VALUATION AND QUALIFYING ACCOUNTS**  
(in thousands)

Description	Balances at Beginning of Period	Acquisitions and Dispositions	Charged to Operations (a)	Charged to Other Accounts	Deductions (b)	Balances at End of Period
<b>Allowance for Doubtful Accounts (c)</b>						
Year ended December 31, 2011	\$ 495,486	\$ -	\$ 746,450	\$ -	\$ (662,964)	\$ 578,972
Year ended December 31, 2010	455,705	291	662,239	-	(622,749)	495,486
Year ended December 31, 2009	449,031	(12,975)	606,812	-	(587,163)	455,705

- (a) Charges to operations include amounts related to provisions for doubtful accounts, before recoveries of accounts receivable that were previously written off.
- (b) Accounts receivable written off as uncollectible.
- (c) This table includes the activity of discontinued operations, as identified at Note 10 to the Consolidated Financial Statements in Item 8 of Part II.

## SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

### HEALTH MANAGEMENT ASSOCIATES, INC.

By: /s/ Gary D. Newsome President and Chief Executive Officer February 21, 2012  
Gary D. Newsome

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

<u>/s/ William J. Schoen</u> <u>William J. Schoen</u>	Chairman of the Board of Directors	February 21, 2012
<u>/s/ Gary D. Newsome</u> <u>Gary D. Newsome</u>	President, Chief Executive Officer and Director (Principal Executive Officer)	February 21, 2012
<u>/s/ Kelly E. Curry</u> <u>Kelly E. Curry</u>	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 21, 2012
<u>/s/ Gary S. Bryant</u> <u>Gary S. Bryant</u>	Vice President and Controller (Principal Accounting Officer)	February 21, 2012
<u>/s/ Kent P. Dauten</u> <u>Kent P. Dauten</u>	Director	February 21, 2012
<u>/s/ Pascal J. Goldschmidt</u> <u>Pascal J. Goldschmidt, M.D.</u>	Director	February 21, 2012
<u>/s/ Donald E. Kiernan</u> <u>Donald E. Kiernan</u>	Director	February 21, 2012
<u>/s/ Robert A. Knox</u> <u>Robert A. Knox</u>	Director	February 21, 2012
<u>/s/ Vicki A. O'Meara</u> <u>Vicki A. O'Meara</u>	Director	February 21, 2012
<u>/s/ William C. Steere, Jr.</u> <u>William C. Steere, Jr.</u>	Director	February 21, 2012
<u>/s/ Randolph W. Westerfield</u> <u>Randolph W. Westerfield, Ph.D.</u>	Director	February 21, 2012

## INDEX TO EXHIBITS

### (2) Plan of acquisition, reorganization, arrangement, liquidation or succession

Not applicable.

### (3) (i) Articles of Incorporation

3.1 Fifth Restated Certificate of Incorporation, previously filed and included as Exhibit 3.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 1995 (SEC File No. 000-18799), is incorporated herein by reference.

3.2 Certificate of Amendment to Fifth Restated Certificate of Incorporation, previously filed and included as Exhibit 3.2 to the Company's Annual Report on Form 10-K for the fiscal year ended September 30, 1999, is incorporated herein by reference.

### (ii) By-laws

3.3 By-laws, as amended and restated, previously filed and included as Exhibit 3.1 to the Company's Current Report on Form 8-K dated December 7, 2010, are incorporated herein by reference.

### (4) Instruments defining the rights of security holders, including indentures

4.1 Specimen Stock Certificate, previously filed and included as Exhibit 4.11 to the Company's Annual Report on Form 10-K for the fiscal year ended September 30, 1992 (SEC File No. 000-18799), is incorporated herein by reference.

4.2 Indenture, dated as of April 21, 2006, between the Company and U.S. Bank National Association pertaining to the Company's 6.125% Senior Notes due 2016, previously filed and included as Exhibit 4.1 to the Company's Current Report on Form 8-K dated April 18, 2006, is incorporated herein by reference.

4.3 Form of Global Note for the Company's 6.125% Senior Notes due 2016, previously filed and included as part of Exhibit 4.1 to the Company's Current Report on Form 8-K dated April 18, 2006, is incorporated herein by reference.

4.4 Supplemental Indenture, dated as of February 28, 2007, between the Company and U.S. Bank National Association pertaining to the Company's 6.125% Senior Notes due 2016, previously filed and included as Exhibit 4.7 to the Company's Annual Report on Form 10-K for the year ended December 31, 2009, is incorporated herein by reference.

4.5 Credit Agreement dated as of February 16, 2007 among the Company; Bank of America, N.A., as Lender, Administrative Agent, Swing Line Lender and Letter of Credit ("L/C") Issuer; Wachovia Bank, National Association, as Lender, Syndication Agent and L/C Issuer; Citicorp USA Inc., JPMorgan Chase Bank, N.A. and SunTrust Bank, as Lenders and Co-Documentation Agents; and certain other lenders that are parties thereto (includes form of Term B Note, form of Revolving Credit Note, form of Guaranty and form of Security Agreement), previously filed on July 8, 2009 and included as Exhibit 99.1 to the Company's Current Report on Form 8-K/A dated February 16, 2007, is incorporated herein by reference.

4.6 Indenture, dated as of May 21, 2008, between the Company and U.S. Bank, National Association pertaining to the Company's 3.75% Convertible Senior Subordinated Notes due 2028 issued by the Company, previously filed and included as Exhibit 4.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2008, is incorporated herein by reference.

4.7 Form of 3.75% Convertible Senior Subordinated Note due 2028 issued by the Company, previously filed and included as part of Exhibit 4.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2008, is incorporated herein by reference.

- 4.8 Credit Agreement, dated as of September 30, 2011, among Knoxville HMA Holdings, LLC and certain of its subsidiaries, SunTrust Bank, as Administrative Agent, Lender, Swingline Lender and Issuing Bank, and Deutsche Bank Trust Company Americas, The Royal Bank of Scotland PLC, Wells Fargo Bank, N.A., Bank of America, N.A. and Barclays Bank PLC, as Lenders (includes the form of the notes evidencing the term loan facility and the revolving credit facility), previously filed on January 12, 2012 and included as Exhibit 4.1 to the Company's Current Report on Form 8-K/A (Amendment No. 1) dated November 18, 2011, is incorporated herein by reference.
- 4.9 Security Agreement, dated as of September 30, 2011, by Knoxville HMA Holdings, LLC and certain of its subsidiaries in favor of SunTrust Bank, as Administrative Agent under the Credit Agreement with a syndicate of banks, dated as of September 30, 2011, previously filed and included as Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2011, is incorporated herein by reference.
- 4.10 Indenture, dated as of November 18, 2011, among the Company, each of the subsidiary guarantors party thereto and U.S. Bank, National Association pertaining to the Company's 7.375% Senior Notes due 2020 (includes the form of the related notes).
- 4.11 Registration Rights Agreement, dated as of November 18, 2011, among the Company, the guarantors party thereto, Deutsche Bank Securities Inc. and Wells Fargo Securities, LLC pertaining to the Company's 7.375% Senior Notes due 2020.
- 4.12 Credit Agreement, dated as of November 18, 2011, among the Company, Wells Fargo Bank, National Association, as Administrative Agent, Swing Line Lender and Letter of Credit Issuer, Wells Fargo Securities, LLC, as Joint Lead Arranger and Joint Bookrunner, Deutsche Bank Securities, Inc., as Joint Lead Arranger, Joint Bookrunner and Syndication Agent, Citigroup Global Markets Inc., as Joint Bookrunner, Citibank, N.A., as Co-Documentation Agent, SunTrust Robinson Humphrey, Inc., as Joint Bookrunner, SunTrust Bank, as Co-Documentation Agent, Barclays Capital, as Joint Bookrunner, Barclays Bank PLC, as Co-Documentation Agent, and each of RBS Securities Inc., J.P. Morgan Securities LLC and Morgan Stanley Senior Funding, Inc., as Managing Agents, and certain other lenders thereto (includes the form of the related notes).
- 4.13 Security Agreement, dated as of November 18, 2011, among the Company, the guarantors party thereto and Wells Fargo Bank, National Association, as Collateral Agent, pertaining to the Company's Credit Agreement, dated as of November 18, 2011.

**(9) Voting trust agreement**

Not applicable.

**(10) Material contracts**

Exhibits 4.2 through 4.13 referenced under (4) of this Index to Exhibits are incorporated herein by reference.

- 10.1 Registration Agreement dated September 2, 1988 between HMA Holding Corp., First Chicago Investment Corporation, Madison Dearborn Partners IV, Prudential Venture Partners, Prudential Venture Partners II, William J. Schoen, Kelly E. Curry, Stephen M. Ray, Robb L. Smith, George A. Taylor and Earl P. Holland, previously filed and included as Exhibit 10.23 to the Company's Registration Statement on Form S-1 (Registration No. 33-36406), is incorporated herein by reference.
- †10.2 Restructuring Agreement, dated as of September 30, 2009, among Health Management Associates, Inc., Carolinas Holdings, LLC, Carolinas JV Holdings, L.P., Novant Health, Inc. and Foundation Health Systems Corp., previously filed and included as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2009, is incorporated herein by reference.

- 10.3 Asset Purchase Agreement, dated June 30, 2011, between Health Management Associates, Inc., Knoxville HMA Holdings, LLC, Catholic Health Partners and Mercy Health Partners, Inc., previously filed on October 27, 2011 and included as Exhibit 2.1 to the Company's Current Report on Form 8-K/A (Amendment No. 2) dated June 30, 2011, is incorporated herein by reference.
- \*10.4 Health Management Associates, Inc. Stock Option Plan for Outside Directors, previously filed and included as Exhibit 10.5 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 1995 (SEC File No. 000-18799), is incorporated herein by reference.
- \*10.5 Amendment No. 1 to the Health Management Associates, Inc. Stock Option Plan for Outside Directors, previously filed and included as Exhibit 10.59 to the Company's Annual Report on Form 10-K for the fiscal year ended September 30, 1995 (SEC File No. 000-18799), is incorporated herein by reference.
- \*10.6 Form of Director Stock Option Agreement under the Health Management Associates, Inc. Stock Option Plan for Outside Directors, as amended, previously filed and included as Exhibit 10.35 to the Company's Annual Report on Form 10-K for the fiscal year ended September 30, 2004, is incorporated herein by reference.
- \*10.7 Health Management Associates, Inc. 2006 Outside Director Restricted Stock Award Plan, previously filed and included as Appendix A to the Company's definitive Proxy Statement filed on January 19, 2006, is incorporated herein by reference.
- \*10.8 Amendment to the Health Management Associates, Inc. 2006 Outside Director Restricted Stock Award Plan, previously filed and included as Exhibit 10.25 to the Company's Annual Report on Form 10-K for the year ended December 31, 2009, is incorporated herein by reference.
- \*10.9 Form of Restricted Stock Award Plan Notice under the Health Management Associates, Inc. 2006 Outside Director Restricted Stock Award Plan, previously filed and included as Exhibit 99.1 to the Company's Current Report on Form 8-K dated February 21, 2006, is incorporated herein by reference.
- \*10.10 First Amendment to Employment Agreement between the Company and William J. Schoen, dated February 6, 2007, previously filed and included as Exhibit 99.1 to the Company's Current Report on Form 8-K dated February 6, 2007, is incorporated herein by reference; and Employment Agreement for William J. Schoen made as of January 2, 2001, previously filed and included as Exhibit 99.2 to the Company's Registration Statement on Form S-8 (Registration No. 333-53602), is incorporated herein by reference.
- \*10.11 Fourth Amendment and Restatement of the Health Management Associates, Inc. Supplemental Executive Retirement Plan, previously filed and included as Exhibit 99.1 to the Company's Current Report on Form 8-K dated December 2, 2008, is incorporated herein by reference.
- \*10.12 The Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit A to the Company's definitive Proxy Statement filed on March 31, 2008, is incorporated herein by reference.
- \*10.13 Amendment No. 1 to the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit 10.24 to the Company's Annual Report on Form 10-K for the year ended December 31, 2009, is incorporated herein by reference.
- \*10.14 Amendment No. 2 to the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit A to the Company's definitive Proxy Statement filed on April 5, 2010, is incorporated herein by reference.

- \*10.15 Form of Stock Option Agreement under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit 10.36 to the Company's Annual Report on Form 10-K for the fiscal year ended September 30, 2004, is incorporated herein by reference.
- \*10.16 Form of Contingent Stock Award under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit 10.32 to the Company's Annual Report on Form 10-K for the year ended December 31, 2007, is incorporated herein by reference.
- \*10.17 Form of Deferred Stock Award under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit 10.33 to the Company's Annual Report on Form 10-K for the year ended December 31, 2007, is incorporated herein by reference.
- \*10.18 Form of Deferred Stock Award under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan for independent directors serving on the Company's Board of Directors, previously filed and included as Exhibit 10.19 to the Company's Annual Report on Form 10-K for the year ended December 31, 2010, is incorporated herein by reference.
- \*10.19 Form of Restricted Stock Award and Cash Performance Award for the year ended December 31, 2008 under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit 10.26 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008, is incorporated herein by reference.
- \*10.20 Stock Option Award granted to Gary D. Newsome under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit 10.28 to the Company's Annual Report on Form 10-K for the year ended December 31, 2008, is incorporated herein by reference.
- \*10.21 The forms of Restricted Stock Award and Cash Performance Award for the years ended December 31, 2010 and 2009 under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan are the same, in all material respects, as the form of award previously filed and included as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2009, which exhibit is incorporated herein by reference.
- \*10.22 The form of Restricted Stock Award and Cash Performance Award for the year ended December 31, 2011 under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit 10.23 to the Company's Annual Report on Form 10-K for the year ended December 31, 2010, is incorporated herein by reference.
- \*10.23 Certain executive officer compensation information, including stock-based compensation under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed on the Company's Current Report on Form 8-K dated February 15, 2011, is incorporated herein by reference.
- \*10.24 Certain executive officer compensation information, previously filed and included in Item 5 of Part II of the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2011, is incorporated herein by reference.
- \*10.25 Agreement and Release, dated as of January 19, 2012, between Hospital Management Services of Florida, Inc. and Timothy R. Parry, previously filed and included as Exhibit 99.1 to the Company's Current Report on Form 8-K dated January 17, 2012, is incorporated herein by reference.

- \*10.26 Cash Performance Award granted to Joseph C. Meek under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit 10.3 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2010, is incorporated herein by reference.
- \*10.27 Deferred Stock Award granted to Joseph C. Meek under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit 10.4 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2010, is incorporated herein by reference.
- \*10.28 The form of Deferred Stock Award granted to Joseph C. Meek for the year ended December 31, 2011 under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed and included as Exhibit 10.28 to the Company's Annual Report on Form 10-K for the year ended December 31, 2010, is incorporated herein by reference.
- \*10.29 Certain executive officer compensation information, including stock-based compensation under the Health Management Associates, Inc. Amended and Restated 1996 Executive Incentive Compensation Plan, previously filed on the Company's Current Report on Form 8-K dated February 21, 2012, is incorporated herein by reference.

**(11) Statement re computation of per share earnings**

Not applicable.

**(12) Statements re computation of ratios**

Not applicable.

**(13) Annual report to security holders, Form 10-Q or quarterly report to security holders**

Not applicable.

**(14) Code of Ethics**

Not applicable.

**(16) Letter re change in certifying accountant**

Not applicable.

**(18) Letter re change in accounting principles**

Not applicable.

**(21) Subsidiaries of the registrant**

21.1 Subsidiaries of the registrant.

**(22) Published report regarding matters submitted to vote of security holders**

Not applicable.

**(23) Consents of experts and counsel**

23.1 Consent of Ernst & Young LLP.

**(24) Power of attorney**

Not applicable.

**(31) Rule 13a-14(a)/15d-14(a) Certifications**

- 31.1 Rule 13a-14(a)/15d-14(a) Certification of Principal Executive Officer.
- 31.2 Rule 13a-14(a)/15d-14(a) Certification of Principal Financial Officer.

**(32) Section 1350 Certifications**

- 32.1 Section 1350 Certifications.

**(99) Additional exhibits**

Not applicable.

**(101) Interactive data files**

- \*\*101.INS XBRL Instance Document
- \*\*101.SCH XBRL Taxonomy Extension Schema Document
- \*\*101.CAL XBRL Taxonomy Extension Calculation Linkbase Document
- \*\*101.DEF XBRL Taxonomy Extension Definition Linkbase Document
- \*\*101.LAB XBRL Taxonomy Extension Label Linkbase Document
- \*\*101.PRE XBRL Taxonomy Extension Presentation Linkbase Document

\* Management contract or compensatory plan or arrangement.

\*\* Pursuant to Rule 406T of Regulation S-T, the information in this exhibit shall not be deemed to be "filed" for purposes of Section 18 of the Securities Exchange Act of 1934, or otherwise subject to the liability of that section, and shall not be incorporated by reference into any registration statement, prospectus or other document filed under the Securities Act of 1933, or the Securities Exchange Act of 1934, except as shall be expressly set forth by specific reference in such filings.

† Health Management Associates, Inc. requested confidential treatment of certain information contained in this exhibit. Such information was filed separately with the Securities and Exchange Commission pursuant to an application for confidential treatment under 17 C.F.R. §§ 200.80(b)(4) and 240.24b-2. On November 18, 2009, the Securities and Exchange Commission approved the request pursuant to an Order Granting Confidential Treatment.

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**HOME OFFICE**

5811 Pelican Bay Boulevard, Suite 500  
Naples, Florida 34108-2710  
239-598-3131

**INTERNET ADDRESS**

[www.hma.com](http://www.hma.com)

**ANNUAL REPORT TO THE SEC**

Health Management's Annual Report on Form 10-K, filed with the Securities and Exchange Commission (SEC), and other filings made by Health Management with the SEC may be obtained by writing to Health Management at its address listed above. Such information filed by Health Management with the SEC is also available by accessing Health Management's website at [www.hma.com](http://www.hma.com).

**NYSE SYMBOL**

HMA

**INDEPENDENT REGISTERED  
PUBLIC ACCOUNTING FIRM**

Ernst & Young LLP  
Miami, Florida

**ANNUAL MEETING**

Stockholders are cordially invited to attend the 2012 Annual Meeting of Stockholders, which will be held at 1:30 p.m., local time, on Tuesday, May 22, 2012, at the Ritz-Carlton Golf Resort Naples, 2600 Tiburón Drive, Naples, FL, 34109.

Management urges all stockholders to vote their proxies and thus participate in the decisions that will be made at the Annual Meeting.

**TRANSFER AGENT**

American Stock Transfer & Trust Company  
59 Maiden Lane, Plaza Level  
New York, New York 10038  
(800) 937-5449  
[www.amstock.com](http://www.amstock.com)

For a change of name, address, or to replace lost stock certificates, write or call the Transfer Agent's Securities Transfer Division.

**SECURITIES ANALYST CONTACT**

John C. Merriwether  
Vice President - Financial Relations  
239-598-3131

**ANALYST COVERAGE**

Argus Research Company  
Auriga USA  
Bank of America / Merrill Lynch  
Barclays Capital  
BMO Capital  
Cantor Fitzgerald  
Citigroup  
Credit Suisse  
CRT Capital Group  
Deutsche Bank  
Jefferies & Co.  
Lazard Capital  
Leerink Swann & Company  
Mizuho Securities  
Morgan Stanley  
Oppenheimer  
Raymond James  
RBC Capital Markets  
Robert W. Baird & Company  
Suntrust  
Susquehanna Financial Group  
UBS  
Wells Fargo

**FORWARD-LOOKING STATEMENTS**

Certain statements contained in this Annual Report, including, without limitation, statements containing the words "believe," "anticipate," "intend," "expect," "may," "could," "plan," "continue," "should," "project," "estimate" and words of similar import, constitute "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933, as amended, and Section 21E of the Securities Exchange Act of 1934, as amended. Forward-looking statements may include projections of revenue, provisions for doubtful accounts, income or loss, capital expenditures, debt structure, principal payments on debt, capital structure, the amount and timing of funds under the meaningful use measurement standard of various Healthcare Information Technology ("HCIT") incentive programs, other financial items and operating statistics, statements regarding our plans and objectives for future operations, acquisitions, acquisition financing, divestitures and other transactions, statements of future economic performance, statements regarding our legal proceedings and other loss contingencies, statements regarding market risk exposures, statements regarding the effects and/or interpretations of recently enacted or future health care laws and regulations, statements of the assumptions underlying or relating to any of the foregoing statements, and statements that are other than statements of historical fact.

Forward-looking statements are based on our current plans and expectations and involve known and unknown risks, uncertainties and other factors that may cause our actual results, performance, achievements or industry results to be materially different from any future results, performance or achievements expressed or implied by our forward-looking statements. Such factors include, among other things, the risks and uncertainties identified by us that are more fully described in the accompanying 2011 Annual Report on Form 10-K under the heading "Risk Factors" in Item 1A of Part I. Furthermore, we operate in a continually changing business and regulatory environment and new risk factors emerge from time to time. We cannot predict what these new risk factors may be, nor can we assess the impact, if any, of such new risk factors on our business or results of operations or the extent to which any factor or combination of factors may cause our actual results to differ materially from those expressed or implied by any of our forward-looking statements.

Undue reliance should not be placed on our forward-looking statements. Except as required by law, we disclaim any obligation to update our risk factors or to publicly announce updates to the forward-looking statements contained in this Annual Report to reflect new information, future events or other developments.

## OUR FAMILIES AND COMMUNITIES



Riverview Regional  
Gadsden, AL



Stringfellow Memorial Hospital  
Anniston, AL



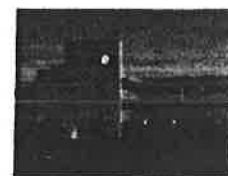
Sparks Health System  
Fort Smith, AR



Summit Medical Center  
Van Buren, AR



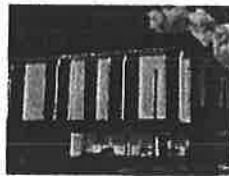
Bartow Regional  
Bartow, FL



Brooksville Regional  
Brooksville, FL



Pasco Regional  
Dade City, FL



Peace River Regional  
Port Charlotte, FL



Physicians Regional-Collier Blvd  
Naples, FL



Physicians Regional-Pine Ridge  
Naples, FL



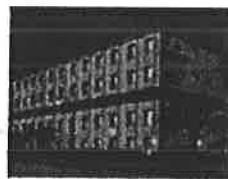
Santa Rosa Medical Center  
Milton, FL



Sebastian River Medical Center  
Sebastian, FL



St. Cloud Regional  
St. Cloud, FL



Venice Regional  
Venice, FL



Wuesthoff Medical Center-Melbourne  
Melbourne, FL



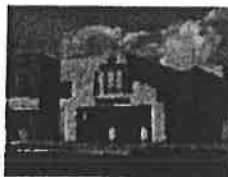
Wuesthoff Medical Center-Rockledge  
Rockledge, FL



Barrow Regional  
Winder, GA



East Georgia Regional  
Statesboro, GA



Gilmore Memorial Regional  
Amory, MS



Madison River Oaks  
Canton, MS



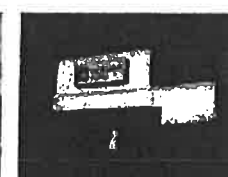
Natchez Community Hospital  
Natchez, MS



Northwest Mississippi Regional  
Clarksdale, MS



River Oaks Hospital  
Flowood, MS



Woman's Hospital at River Oaks  
Flowood, MS



Sandhills Regional  
Hamlet, NC



Medical Center of  
Southeastern Oklahoma  
Durant, OK



Midwest Regional  
Midwest City, OK



Carlisle Regional  
Carlisle, PA



Heart of Lancaster Regional  
Lititz, PA



Lancaster Regional  
Lancaster, PA



LaFollette Medical Center  
LaFollette, TN



Newport Medical Center  
Newport, TN



North Knoxville Medical Center  
Powell, TN



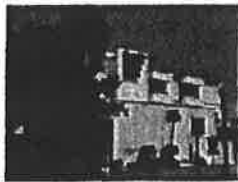
Physicians Regional  
Knoxville, TN



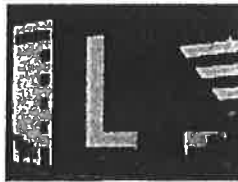
St. Mary's Medical Center  
of Scott County  
Oneida, TN



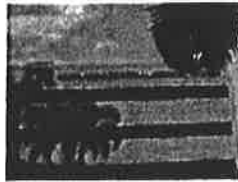
Turkey Creek Medical Center  
Knoxville, TN



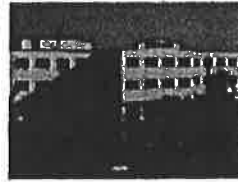
Charlotte Regional  
Punta Gorda, FL



Heart of Florida Regional  
Greater Haines City, FL



Highlands Regional  
Sebring, FL



Lehigh Regional  
Lehigh Acres, FL



Lower Keys Medical Center  
Key West, FL



Seven Rivers Regional  
Crystal River, FL



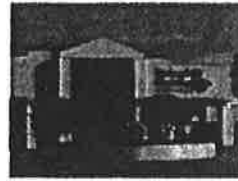
Shands Lake Shore Regional  
Lake City, FL



Shands Live Oak Regional  
Live Oak, FL



Shands Starke Regional  
Starke, FL



Spring Hill Regional  
Spring Hill, FL



Walton Regional  
Monroe, GA



Paul B. Hall Regional  
Paintsville, KY



Biloxi Regional  
Biloxi, MS



Central Mississippi Medical Center  
Jackson, MS



Crossgates River Oaks Hospital  
Brandon, MS



Tri-Lakes Medical Center  
Batesville, MS



Poplar Bluff Regional  
Poplar Bluff, MO



Twin Rivers Regional  
Kennett, MO



Davis Regional  
Statesville, NC



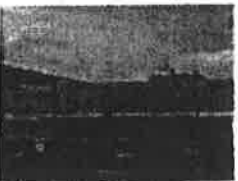
Lake Norman Regional  
Mooresville, NC



Carolina Pines Regional  
Hartsville, SC



Chester Regional  
Chester, SC



Horton Regional  
Tullahoma, TN



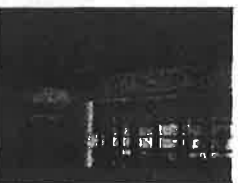
Jamestown Regional  
Jamestown, TN



Jefferson Memorial Hospital  
Jefferson City, TN



University Medical Center  
Lebanon, TN



Dallas Regional  
Mesquite, TX



Toppenish Community Hospital  
Toppenish, WA



Yakima Regional  
Yakima, WA



Williamson Memorial Hospital  
Williamson, WV

# Board for Licensing Health Care Facilities



State of Tennessee

## DEPARTMENT OF HEALTH

*This is to certify, that a license is hereby granted by the State Department of Health to*

0000000048

No. of Beds 0085

HMA FENTRESS COUNTY GENERAL HOSPITAL, LLC

to conduct and maintain a

Hospital

JAMESTOWN REGIONAL MEDICAL CENTER

Located at

436 CENTRAL AVENUE WEST, JAMESTOWN

County of

FENTRESS

, Tennessee.

*This license shall expire* OCTOBER 06, 2013, and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.

*In Witness Whereof, we have hereunto set our hand and seal of the State this* 1ST day of JULY, 2012.

GENERAL HOSPITAL  
PEDIATRIC BASIC HOSPITAL



By

*Vernon J. Davis, MPH*

DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By

*John J. Davis, Jr.*

COMMISSIONER

**Attachment C.Orderly Development.7.d**

# Jamestown Regional Medical Center

Jamestown, TN

has been Accredited by



## The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the  
Hospital Accreditation Program

November 20, 2009

Accreditation is customarily valid for up to 39 months.

*David L. Naisbald*

David L. Naisbald, M.D.  
Chairman of the Board

Organization ID # 7841  
First Report Date 2/22/10

*Mark Chasin*

Mark Chasin, M.D.  
President

The Joint Commission is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation requirements of individual organizations can be obtained through The Joint Commission's web site at [www.jointcommission.org](http://www.jointcommission.org).

AMIA



STATE OF TENNESSEE  
HEALTH SERVICES AND DEVELOPMENT AGENCY

500 Deaderick Street  
Suite 850  
Nashville, Tennessee 37243  
741-2364

December 3, 2012

Melanie B. Robinson, Regional Director, Planning  
Health Management Associates  
200 E. Blount Ave., Suite 600  
Knoxville, TN 37920

RE: Certificate of Need Application -- HMA Fentress County Hospital, LLC d/b/a Jamestown  
Regional Medical Center - CN1211-055

Dear Ms. Robinson:

This is to acknowledge the November 28, 2012 receipt of supplemental information to your application for a Certificate of Need for the conversion of six (6) existing acute care hospital beds to swing beds. The initiation of the swing bed service will not affect the licensing bed complement of the hospital. No other services will be initiated or discontinued, and no major medical equipment is requested. No facility renovations are required for this project. The project cost is \$30,677.00.

Please be advised that your application is now considered to be complete by this office. Your application is being forwarded to the Tennessee Department of Health and/or its representative for review.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on December 1, 2012. The first sixty (60) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the sixty (60) day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on February 27, 2013.

Melanie B. Robinson, Regional Director, Planning  
December 3, 2012  
Page 2

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

- (1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.
- (2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,



Melanie M. Hill  
Executive Director

MMH:MAB

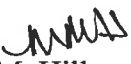
cc: Tere Hendricks, Director, Division of Health Statistics



STATE OF TENNESSEE  
HEALTH SERVICES AND DEVELOPMENT AGENCY  
500 Deaderick Street  
Suite 850  
Nashville, Tennessee 37243  
741-2364

MEMORANDUM

TO: Tere Hendricks, Director  
Office of Policy, Planning and Assessment  
Division of Health Statistics  
Cordell Hull Building, 6th Floor  
425 Fifth Avenue North  
Nashville, Tennessee 37247

FROM:   
Melanie M. Hill  
Executive Director

DATE: December 3, 2012

RE: Certificate of Need Application  
HMA Fentress County Hospital, LLC d/b/a Jamestown Regional  
Medical Center - CN1211-055

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on December 1, 2012 and end on February 1, 2013.

Should there be any questions regarding this application or the review cycle, please contact this office.

MMH:MAB

Enclosure

cc: Melanie B. Robinson, Regional Director, Planning



## LETTER OF INTENT TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

2012 NOV -7 AM 9:57

The Publication of Intent is to be published in the Fentress Courier which is a newspaper  
(Name of Newspaper)  
of general circulation in Fentress County, Tennessee, on or before November 7, 2012, for one day.  
(County) (Month / day)(Year)

=====

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that: HMA Fentress County Hospital, LLC, d/b/a Jamestown Regional Medical Center Hospital  
(Name of Applicant) (Facility Type-Existing)

owned by: HMA Fentress County Hospital with an ownership type of Limited Liability Corporation and to be managed by: HMA Fentress County Hospital, LLC intends to file an application for a Certificate of Need for: the establishment of six (6) swing beds and the initiation of swing bed services at Jamestown Regional Medical Center, which is located at 436 Central Avenue West, Jamestown, Tennessee 38556. Six (6) existing medical/surgical beds will be converted to swing beds. The number of licensed beds will not change. No other services will be initiated or discontinued and no major medical equipment is requested. No facility renovations are required for this project. The anticipated total cost of the project is \$30,677.

The anticipated date of filing the application is: November 12, 2012

The contact person for this project is Melanie B. Robinson Regional Director, Planning and Business Development  
(Contact Name) (Title)


who may be reached at: Tennova Healthcare 200 E. Blount Ave., Suite 600  
(Company Name) (Address)

Knoxville  
(City)

Tennessee  
(State)

37920  
(Zip Code)

865 / 632-5604  
(Area Code / Phone Number)

  
(Signature)

October 5, 2012  
(Date)

melanie.robinson@hma.com  
(E-mail Address)

=====

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency  
Andrew Jackson Building  
500 Deaderick Street, Suite 850  
Nashville, Tennessee 37243

=====

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

=====

# **Copy**

## **Supplemental #2**

### **HMA Fentress**

### **CN1211-055**



2012 NOV 27 AM 9 51

November 26, 2012

Mr. Phillip Earhart, Health Services Development Examiner  
Tennessee Health Services and Development Agency  
Andrew Jackson Building  
500 Deaderick Street, Suite 850  
Nashville, TN 37243

Re: CN1211-055 – Additional Response to Supplemental Questions

Dear Mr. Earhart:

Per our discussion, enclosed please find, in triplicate, documentation of the existence of Jamestown Regional Medical Center's LLC, as well as an updated Historical Data Chart and Projected Data Chart.

Thank you for the opportunity to provide further information.

Sincerely,

Melanie B. Robinson  
Regional Director, Planning and Business Development

November 20, 2012

10:00am



2012 NOV 27 AM 9:53

**STATE OF TENNESSEE**  
**Tom Hargett, Secretary of State**  
 Division of Business Services  
 William R. Snodgrass Tower  
 312 Rosa L. Parks AVE, 6th FL  
 Nashville, TN 37243-1102

### Filing Information

Name: **HMA FENTRESS COUNTY GENERAL HOSPITAL, LLC**

#### General Information

<b>SOS Control # :</b>	<b>601484</b>	Formation Locale: TENNESSEE
Filing Type:	Limited Liability Company - Domestic	Date Formed: 04/29/2009
Filing Date:	04/29/2009 12:07 PM	Fiscal Year Close 12
Status:	Active	Member Count: 1
Duration Term:	Perpetual	
Managed By:	Manager Managed	

#### Registered Agent Address

C T CORPORATION SYSTEM  
 STE 2021  
 800 S GAY ST  
 KNOXVILLE, TN 37929-9710

#### Principal Address

436 CENTRAL AVE W  
 JAMESTOWN, TN 38556-3031

The following document(s) was/were filed in this office on the date(s) indicated below:

<u>Date Filed</u>	<u>Filing Description</u>	<u>Image #</u>
03/21/2012	2011 Annual Report	A0110-1996
	Principal Address 1 Changed From: 5811 PELICAN BAY BLV To: 436 CENTRAL AVE W	
	Principal City Changed From: NAPLES To: JAMESTOWN	
	Principal State Changed From: FL To: TN	
	Principal Postal Code Changed From: 34108-2710 To: 38556-3031	
	Principal County Changed From: No value To: FENTRESS COUNTY	
03/03/2011	2010 Annual Report	A0058-3142
03/15/2010	2009 Annual Report	A0010-0408
06/16/2009	Assumed Name	6553-0713
05/04/2009	Conversion	6529-2204
05/04/2009	Initial Filing	6529-2209
04/29/2009	Initial Filing	6525-3166
04/29/2009	Merger - Survivor	6525-3168
	Merged Control # Changed From: 000160892	
	Merged Control # Changed From: 000601484	

**Filing Information****Name: HMA FENTRESS COUNTY GENERAL HOSPITAL, LLC**

<b>Active Assumed Names (if any)</b>	<b>Date</b>	<b>Expires</b>
JAMESTOWN REGIONAL MEDICAL CENTER	06/16/2009	06/16/2014

## HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

	Year <u>2009</u>	Year <u>2010</u>	Year <u>2011</u>
A. Utilization Data (Admissions)	<u>2,487</u>	<u>2,307</u>	<u>2,289</u>
B. Revenue from Services to Patients			
1. Inpatient Services	<u>\$35,802,115</u>	<u>\$36,741,393</u>	<u>\$36,922,288</u>
2. Outpatient Services	<u>39,226,632</u>	<u>38,481,703</u>	<u>43,080,887</u>
3. Emergency Services			
4. Other Operating Revenue (Specify) <u>Cafeteria, Medical</u>	<u>53,003</u>	<u>42,433</u>	<u>50,269</u>
<u>Record Fees, Nursing Student Fees</u>			
<b>Gross Operating Revenue</b>	<b><u>\$75,081,750</u></b>	<b><u>\$75,265,529</u></b>	<b><u>\$80,053,444</u></b>
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	<u>\$46,356,633</u>	<u>\$47,140,334</u>	<u>\$49,311,303</u>
2. Provision for Charity Care	<u>7,845,263</u>	<u>8,314,376</u>	<u>9,596,874</u>
3. Provisions for Bad Debt	<u>2,914,185</u>	<u>2,550,841</u>	<u>2,832,644</u>
<b>Total Deductions</b>	<b><u>\$57,116,081</u></b>	<b><u>\$58,005,551</u></b>	<b><u>\$61,740,821</u></b>
<b>NET OPERATING REVENUE</b>	<b><u>\$17,965,669</u></b>	<b><u>\$17,259,978</u></b>	<b><u>\$18,312,623</u></b>
D. Operating Expenses			
1. Salaries and Wages	<u>\$10,039,123</u>	<u>\$9,601,915</u>	<u>\$8,996,114</u>
2. Physician's Salaries and Wages			
3. Supplies	<u>1,918,924</u>	<u>1,763,487</u>	<u>1,665,688</u>
4. Taxes			
5. Depreciation	<u>1,170,174</u>	<u>1,151,471</u>	<u>1,004,863</u>
6. Rent	<u>271,963</u>	<u>361,715</u>	<u>376,482</u>
7. Interest, other than Capital	<u>46,601</u>	<u>48,663</u>	<u>53,152</u>
8. Management Fees:			
a. Fees to Affiliates	<u>996,989</u>	<u>630,953</u>	<u>1,292,053</u>
b. Fees to Non-Affiliates			
9. Other Expenses – Specify on separate page 14	<u>4,160,429</u>	<u>5,380,448</u>	<u>6,478,735</u>
<b>Total Operating Expenses</b>	<b><u>\$18,604,203</u></b>	<b><u>\$18,938,652</u></b>	<b><u>\$19,867,087</u></b>
E. Other Revenue (Expenses) – Net (Specify) _____	<u>\$ _____</u>	<u>\$ _____</u>	<u>\$ _____</u>
<b>NET OPERATING INCOME (LOSS)</b>	<b><u>\$(638,534)</u></b>	<b><u>\$(1,678,674)</u></b>	<b><u>\$(1,554,464)</u></b>
F. Capital Expenditures			
1. Retirement of Principal	<u>\$ _____</u>	<u>\$ _____</u>	<u>\$ _____</u>
2. Interest			
<b>Total Capital Expenditures</b>	<b><u>\$ _____</u></b>	<b><u>\$ _____</u></b>	<b><u>\$ _____</u></b>
<b>NET OPERATING INCOME (LOSS)</b>			
<b>LESS CAPITAL EXPENDITURES</b>	<b><u>\$(638,534)</u></b>	<b><u>\$(1,678,674)</u></b>	<b><u>\$(1,554,464)</u></b>

**HISTORICAL DATA CHART-OTHER EXPENSES**

2012 NOV 27 AM 9 53

**OTHER EXPENSE CATEGORIES:**

	<u>2009</u>	<u>2010</u>	<u>2011</u>
1. Repairs and Maintenance	\$ 506,514	\$ 599,723	\$ 652,005
2. Travel/Mileage	\$ 47,269	\$ 52,759	\$ 68,666
3. Meals	\$ 4,657	\$ 4,803	\$ 4,360
4. Training	\$ 16,789	\$ 29,264	\$ 36,269
5. Dues & Subscriptions	\$ 63,102	\$ 67,521	\$ 71,876
6. Recruitment	\$ 107,747	\$ 34,514	\$ 22,645
7. Insurances	\$1,598,746	\$2,077,797	\$2,741,288
8. Outside Services	<u>\$1,815,605</u>	<u>\$2,514,067</u>	<u>\$2,881,626</u>
<b>Total Other Expenses</b>	<b>\$4,160,429</b>	<b>\$5,380,448</b>	<b>\$6,478,735</b>

**PROJECTED DATA CHART**

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

	<u>Year 1</u>	<u>Year 2</u>
A. Utilization Data (Admissions)	<u>2,432</u>	<u>2,505</u>
B. Revenue from Services to Patients		
1. Inpatient Services	<u>\$46,202,000</u>	<u>\$47,588,060</u>
2. Outpatient Services	<u>59,404,000</u>	<u>61,186,120</u>
3. Emergency Services	<u>                    </u>	<u>                    </u>
4. Other Operating Revenue (Specify) _____	<u>                    </u>	<u>                    </u>
<b>Gross Operating Revenue</b>	<b><u>\$105,606,000</u></b>	<b><u>\$108,774,180</u></b>
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	<u>\$75,424,000</u>	<u>\$77,686,720</u>
2. Provision for Charity Care	<u>3,574,000</u>	<u>3,681,220</u>
3. Provisions for Bad Debt	<u>4,058,000</u>	<u>4,179,740</u>
<b>Total Deductions</b>	<b><u>\$83,056,000</u></b>	<b><u>\$85,547,680</u></b>
<b>NET OPERATING REVENUE</b>	<b><u>\$22,550,000</u></b>	<b><u>\$23,226,500</u></b>
D. Operating Expenses		
1. Salaries and Wages	<u>\$10,295,000</u>	<u>\$10,603,850</u>
2. Physician's Salaries and Wages	<u>20,000</u>	<u>20,600</u>
3. Supplies	<u>2,057,000</u>	<u>2,118,710</u>
4. Taxes	<u>325,000</u>	<u>334,750</u>
5. Depreciation	<u>859,000</u>	<u>884,770</u>
6. Rent	<u>339,000</u>	<u>349,170</u>
7. Interest, other than Capital	<u>                    </u>	<u>                    </u>
8. Management Fees:		
a. Fees to Affiliates	<u>982,000</u>	<u>1,011,460</u>
b. Fees to Non-Affiliates	<u>                    </u>	<u>                    </u>
9. Other Expenses – Specify on separate page 14	<u>6,993,000</u>	<u>7,202,790</u>
<b>Total Operating Expenses</b>	<b><u>\$21,870,000</u></b>	<b><u>\$22,526,100</u></b>
E. Other Revenue (Expenses) -- Net (Specify) _____	<u>\$                    </u>	<u>\$                    </u>
<b>NET OPERATING INCOME (LOSS)</b>	<b><u>\$680,000</u></b>	<b><u>\$700,400</u></b>
F. Capital Expenditures		
1. Retirement of Principal	<u>\$                    </u>	<u>\$                    </u>
2. Interest	<u>                    </u>	<u>                    </u>

**SUPPLEMENTAL- # 2****November 20, 2012****10:00am**

Total Capital Expenditures	\$ _____	\$ _____
NET OPERATING INCOME (LOSS)		
LESS CAPITAL EXPENDITURES	2012 NOV 27 AM 9 53 \$ <u>680,000</u>	\$ <u>700,400</u>

**PROJECTED DATA CHART-OTHER EXPENSES****OTHER EXPENSE CATEGORIES:**

	<u>Year 1</u>	<u>Year 2</u>
1. Repairs and Maintenance	\$ 672,000	\$ 692,160
2. Travel/Mileage	\$ 40,000	\$ 41,200
3. Meals	\$ 3,000	\$ 3,090
4. Training	\$ 29,000	\$ 29,870
5. Dues & Subscriptions	\$ 160,000	\$ 164,800
6. Recruitment	\$ 26,000	\$ 26,780
8. Advertising	\$ 50,000	\$ 51,500
9. Postage	\$ 17,000	\$ 17,510
10. Telephone	\$ 79,000	\$ 81,370
11. Utilities	\$ 387,000	\$ 398,610
7. Insurances	\$1,962,000	\$2,020,860
8. Outside Services	<u>\$3,568,000</u>	<u>\$3,675,040</u>
<b>Total Other Expenses</b>	<b>\$6,993,000</b>	<b>\$7,202,790</b>

**ORIGINAL-**

**SUPPLEMENTAL-1**

**HMA Fentress County  
General Hosp.**

**CN1211-055**



Health Management<sup>TM</sup>  
Associates

SUPPLEMENTAL

2012 NOV 26 AM 9:34

November 21, 2012

Melanie M. Hill, Executive Director  
Tennessee Health Services and Development Agency  
Andrew Jackson Building  
500 Deaderick Street, Suite 850  
Nashville, TN 37243

Re: CN1211-055 – Response to Supplemental Questions

Dear Ms. Hill:

Responses, in triplicate, to your supplemental questions regarding the referenced application are enclosed. The signed and notarized affidavit is also enclosed.

Thank you for the opportunity to provide further information.

Sincerely,

Melanie B. Robinson  
Regional Director, Planning and Business Development

AFFIDAVIT

2012 NOV 26 AM 9:34

STATE OF TENNESSEE

COUNTY OF KnoxNAME OF FACILITY: HMA Fentress County General Hospital

I, Melanie B. Robinson after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Melanie B. Robinson, Director  
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 20<sup>th</sup> day of November, 2012,  
witness my hand at office in the County of Knox, State of Tennessee.

Susan E. England  
NOTARY PUBLIC

My commission expires July 7, 2015.



HF-0043

Revised 7/02

2012 NOV 26 AM 9:34

November 21, 2012

Melanie B. Robinson  
Health Management Associates/Ternnova Healthcare  
200 E. Blount Avenue, Suite 600  
Knoxville, TN 37920

RE: Certificate of Need Application CN1211-055  
HMA Fentress dba/Jamestown Regional Medical Center

Dear Ms. Robinson:

This will acknowledge our November 9, 2012 receipt of your application for a Certificate of Need for the establishment of six (6) swing bed services at Jamestown Regional Medical Center converted from six (6) existing medical/surgical beds.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 4:00 p.m., Friday, November 23, 2012. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

---

**1. Section A, Applicant Profile, Item 4.**

Please provide a copy of the Limited Liability Company (LLC) Certificate of Existence from the Tennessee Secretary of State verifying the LLC is active.

*A copy of the Limited Liability Company (LLC) Certificate of Existence from the Tennessee Secretary of State verifying the LLC is active is attached as Attachment 1.*

**2. Section A, Applicant Profile, Item 5.**

The applicant has indicated there is not a Management/Operating Entity. Although, in Section 7 of the Amended and Restated Operating Agreement attached to Exhibit A, the

Articles of Organization of HMA Fentress County General Hospital, LLC, states “the company shall be managed by Hospital Management Associates, Inc.” Please clarify.

*The response was meant to indicate that there is no outside management company outside the Health Management Associates’ family of companies. Hospital Management Associates, Inc. is a wholly owned subsidiary of Health Management Associates, Inc., the ultimate parent company of HMA Fentress County General Hospital, LLC, d/b/a Jamestown Regional Medical Center. Hospital Management Associates, Inc. provides centralized support services to Jamestown Regional Medical Center, such as Legal, IT, and HR services.*

### **3. Section A, Applicant Profile, Item 6.**

Please provide documentation of HMA Fentress dba/Jamestown Regional Medical Center ownership of the property.

*The property ownership documents are attached as Attachment 3. The attachment includes the following documents:*

- *Order of Default Judgment, dated November 13, 2012, quieting title in favor of HMA Fentress County General Hospital LLC for Parcel 1 (.57 acres) and Parcel 2 (1.49 acres).*
- *Deed for Parcel 3 (2.95 acres, dated December 21, 2001, from Paracelsus Real Estate Corporation to Paracelsus Fentress County General Hospital, Inc.*
- *Certificate of Amendment of Articles of Incorporation of Paracelsus Fentress County General Hospital, Inc., dated January 23, 2002, changing name of Paracelsus Fentress County General Hospital, Inc. to HMA Fentress County General Hospital, Inc.*
- *Certificate of Conversion, dated May 1, 2009, converting HMA Fentress County General Hospital, Inc., to HMA Fentress County General Hospital, LLC.*
- *Deed for Parcel 4 (2.42 acres), dated July 24, 2003, from Mark and Sarah Clapp to HMA Fentress County General Hospital, Inc.*

### **4. Section B, Project Description, Item I.**

What is the age of the physical facility where the proposed six (6) bed swing unit will be located?

*The hospital was built in 1960. The facility is 52 years old.*

Please provide a brief overview and history of the swing bed program.

*The Swing Bed program originated in the 1970’s, with the first swing beds being approved in 1973 in Utah, as a means of solving two issues facing rural hospitals: (1) hospitals were built on a scale that often resulted in more beds than patients to fill them, and (2) frail elderly people who were disabled often needed to be transferred from an acute care setting to a nursing home setting far from home. After several years as a demonstration project, the swing bed concept was broadly accepted and encouraged by the Department of Health & Human Services Centers for Medicare &*

***Medicaid Services (CMS). Today over 60% of all rural hospitals provide swing bed services.***

***According to CMS, hospitals approved to furnish swing bed services may use their beds as needed to furnish either acute or Skilled Nursing Facility (SNF)-level care. The stated purpose of this allowance is to enable rural hospitals to increase Medicare beneficiary access to post-acute SNF care and maximize the efficiency of operations by meeting demands for acute and long-term care. Hospitals that qualify may use any acute care bed within the hospital, with the exception of rehabilitation, psychiatric, or intensive care units, for the provision of swing bed services.***

***In order to qualify for CMS approval to provide Swing Beds, a hospital must meet the following criteria:***

- ***Be located in a rural area***
- ***Have fewer than 100 beds***
- ***Have a Medicare provider agreement as a hospital***
- ***Have not had a swing bed approval terminated within the two years previous to submission of the current application for swing bed approval***
- ***Not have a nursing waiver granted as specified in the “Code of Federal Regulations” (CFR) at 42 CFR 482.66(b)(1-8)***
- ***Be substantially in compliance with the following SNF participation requirements as specified at 42 CFR 482.66(b)(1-8):***
  - ***Residents’ rights;***
  - ***Admission, transfer, and discharge rights;***
  - ***Resident behavior and facility practices;***
  - ***Patient activities;***
  - ***Social services;***
  - ***Discharge planning;***
  - ***Specialized rehabilitation services; and***
  - ***Dental services***

***Jamestown Regional Medical Center understands and intends to comply with all of the criteria required for CMS approval of Swing Bed services. The CMS Fact Sheet describing Swing Bed Services is attached as Attachment 4.***

In order to better understand how a skilled nursing level of care would be differentiated from general acute as it pertains to the proposal, please briefly compare/contrast the key features of the services. In your response, it would be helpful to compare/contrast the primary clinical features that apply such as qualifying clinical conditions/diagnoses, level of physician supervision required, types of services offered, the average length of stay and any other factors that the applicant wishes to provide.

***It is important to note that the bed itself does not “swing,” but rather the services and level of care required by the patient in the bed that swings. In addition to the level of care provided, the way the patient is treated from an accounting and billing standpoint changes as well.***

***The applicant expects that 98+% of the patients utilizing the Swing Bed services require near-acute care as opposed to the kind of chronic or palliative care provided by traditional nursing homes. These are patients who have undergone an acute care, inpatient stay, for various reasons including surgery, hip fractures, pneumonia, or other acute illnesses. For those patients who no longer require the level of nursing provided during an acute stay, but who need near-acute, “long-term” care, such as injections, catheters, intravenous feedings, or rehabilitation services, swing bed***

*services can provide a smooth continuum of care from initial hospital admission through discharge to home or nursing home. The patient benefits from the continuity of care during the healing process. According to the Robert Wood Johnson Foundation Swing Bed Project, swing bed patients nationally have an average length of stay of 20 days, versus the local nursing home length of stay of 55 days, again reinforcing the point that patients using swing beds are in more of a near-acute situation than traditional nursing home patients. Many patients will transition from acute care, to skilled nursing care in a hospital swing bed, and then into a traditional nursing home setting.*

*In terms of comparing clinical care between acute care and skilled nursing, there are some concrete differences. In a skilled nursing bed, the attending physician will not need to see the patient daily, but may see the patient every third or fourth day. The nurses take over more responsibility for the care of the patient than the physician does when the bed "swings" from acute to skilled nursing. The care shifts from diagnosis-centered, doctor-dominated, acute care to the nursing-centered, multidimensional needs of the long-term-care patient. Staff members shift from doing everything for the patient to assisting or allowing the patient to do some tasks for him or herself, for example, feeding and dressing themselves.*

What type of patient activities, social services, specialized rehabilitation services and discharge planning will be needed for the skilled nursing component?

*For the skilled nursing component, the hospital has social work services to identify social and psychosocial needs and connect patients and their families to the appropriate service providers. In addition, physical, occupational, and speech therapies will be provided. The hospital conducts discharge planning for its patients daily and is fully qualified to provide discharge planning services to the skilled nursing patients.*

What are the distinct advantages, other than convenience, for a patient to receive skilled nursing home services in a hospital rather than a free standing nursing home?

*The distinct advantages for a patient receiving skilled nursing home services in a hospital rather than a free standing nursing home are the accessibility to medical services and the ability to have continuity of physician care and oversight throughout the acute and post-acute stay in the hospital. A study conducted by the Robert Wood Johnson Foundation also found that patients who need care following an acute hospital stay to prepare to return home are positive about swing beds; being in a hospital makes them feel better cared for and is less disruptive than moving to a nursing home would have been.*

What type of acute hospitalization and length of stay requirements qualifies a patient for a swing bed?

*There is not a specific type of acute hospitalization that qualifies a patient for a swing bed. CMS does require that the patient have been an inpatient for a medically necessary stay for at least three consecutive calendar days before qualifying for a swing bed. Typical acute care stays that can lead to the need for swing bed services are fractures, mild strokes, heart attacks, and surgical procedures.*

How will consumer choice drive the patient's decision to either step down into a swing bed or into a community based nursing home?

*The Nurse responsible for discharge planning and case management for the patient will discuss the options for long-term care with the patient and the patient's family members. Those options will include a swing bed, a community based nursing home, or a medically or socially appropriate alternative.*

The CV for the proposed Medical Director, Dr. Jonathan Allred, is noted. Please clarify Dr. Allred's experience and expertise with swing bed units and/or patients.

*Dr. Allred is Board Certified in Internal Medicine with Residencies in Internal Medicine and Pediatrics. Dr. Allred has been providing care in rural hospitals for twenty years. He has also had many patients discharged into nursing home care who remain his patients. He has experience treating patients across the continuum of care, from good health through acute illnesses and then post-acute levels of care.*

The applicant states the conversion of six acute care beds to skilled nursing/swing beds is needed to maximize the efficiency of operations and meet the unpredictable demands for acute and skilled level beds. Please clarify what is meant by unpredictable demands and how often has the applicant experienced these demands within the last year.

*As was noted in the application, 338 Jamestown Regional Medical Center acute care patients were discharged into a skilled nursing bed during 2011. In some cases, particularly in the latter half of 2011, an open skilled bed could not be found at the point when discharge from acute care was appropriate, and the patient had to remain in the hospital as an acute care patient for his or her safety. Unfortunately, because hospitals are now paid for services based on a DRG allowable payment, the hospital is not paid for the extra days of care by CMS. If swing bed services are approved, the hospital can provide skilled nursing services to those patients, reducing disruption to the patient until and unless he or she is ready to move to another care setting or go home, and the hospital can be paid for the care it is providing.*

Please indicate the closest nursing home offering skilled nursing services to the applicant and the traveling distance.

*The closest nursing home offering skilled nursing services is Signature Healthcare of Fentress County, which is located in close proximity to the hospital, across the street.*

## **5. Section B, Project Description, Items II. A and II. B**

Please indicate the square footage of the location of the proposed six (6) swing beds including the size of patient rooms. Also, please indicate the total number of private and semi-private beds associated with the proposed swing beds.

*The proposed swing beds are not in a separate unit, but rather any medical/surgical bed in the hospital can "swing" to become a skilled nursing bed, depending on the needs and status of the patient, up to a maximum of six (6) skilled nursing patients at any one time.*

*The total square footage of the nursing/patient care units is 13,567 square feet. The room breakdown is as follows:*

- 13 Private rooms – 120 square feet each*
- 21 Semi-private rooms – 240 square feet each*
- 2 Three-bed wards – 320 square feet each*

Please provide a percentage breakdown on how the applicant will utilize the six (6) proposed swing beds, i.e., skilled care vs. acute care hospital services.

***This application has estimated an average daily census of 5.3 patients needing skilled nursing services. Translated into percentages, it is estimated that 88% of the six (6) bed capacity will be utilized for skilled care.***

For patients requiring Level II skilled nursing care services, are any modifications required to the proposed swing bed area to meet licensure requirements by the Tennessee Department of Health, such as arrangements for privacy, handicapped access, etc.?

***No modifications are required to the proposed swing bed area to meet licensure requirements by the Tennessee Department of Health.***

**6. Section B, Project Description, Item II. C.**

The applicant states almost 15% of Jamestown's RMC's discharges are discharged into another care setting. Please indicate which nursing home received the most discharges for skilled nursing care in 2011.

***Signature Healthcare of Fentress County received the most discharges for skilled nursing care from Jamestown Regional Medical Center in 2011.***

**7. Section B, Project Description, Item IV (Floor Plan)**

Please submit a legible floor plan.

***Unfortunately, an alternative floor plan is not available, and increasing the size of this document does not improve its legibility. The floorplan has been resubmitted as Attachment 7, with the nursing units highlighted, so that it is apparent where the swing beds can be located.***

**8. Section C, Need, Item 1**

Please respond to each principle in the "Five Principles to Achieve Better Healthcare" Section.

***The Five Principles to Achieve Better Healthcare in Tennessee's State Health Plan are:***

- 1. Healthy Lives***
- 2. Access to Care***
- 3. Economic Efficiencies***
- 4. Quality of Care***
- 5. Health Care Workforce***

***This application supports achievement of the Five Principles in the following ways:***

- 1. Healthy Lives. Goal 1F is to "Reduce barriers to becoming healthy for everyone." Two strategies for achieving this goal are supported by this application:***
  - a. Increase community-based, culturally appropriate care, and***
  - b. Support programs that foster good mental and physical health for...the elderly...and other vulnerable populations.***

*Providing skilled nursing in a setting that helps transition elderly patients from acute care to the appropriate longer-term setting by offering skilled nursing beds within the hospital eliminates potential barriers to returning home or into the appropriate long-term care environment.*

*2. Access to Care. The entire focus of this application is to improve access to needed medical services for those patients who are transitioning from an acute care hospital stay and need additional medical services in a near-acute environment.*

*3. Economic Efficiencies. By allowing the hospital to utilize its available beds to provide skilled nursing care, the Agency will be helping the hospital achieve maximum efficiency. According to the Department of Health & Human Services, one of the primary purposes of a swing bed program is to help the hospital maximize its efficiency of operations.*

*4. Quality of Care. While the State Health Plan addresses many issues and has many goals related to quality of care, Goal 4E states "Ensure patients receive well-coordinated...care across all providers, settings, and levels of care." This application, if approved, allows patients to experience coordinated and consistent care in two care settings, acute and skilled nursing care. Having consistency of both physicians and nursing staff for the skilled nursing portion of a hospital stay will promote better quality of care, particularly for those patients requiring more medical services, such as catheters or IV medications.*

*5. Health Care Workforce. This application supports having a strong health care workforce in two ways. First, by allowing for greater flexibility in the use of the hospital beds, it allows Jamestown Regional Medical Center to provide greater stability and higher numbers of patients, thereby ensuring stable employment for the nursing and support staff of the hospital. Second, skilled nursing is more nurse-driven than diagnosis or physician-driven. Providing the Jamestown RMC nursing staff the opportunity to take a greater leadership role in providing patient care promotes professional growth and development of the nursing staff.*

**9. Section C, Need, Item 1.a. (Service Specific Criteria (Swing Bed Services) B.**

Please identify the federal criteria as mandated by the Health Care Financing Administration for a swing bed unit and how the applicant meets those criteria.

*The federal criteria as mandated by CMS for swing beds follow.*

*The Hospital must:*

- *Be located in a rural area, which includes all areas that are not delineated as urbanized by the U.S. Census Bureau based on the most recent census for which data is published (an urbanized area does not include an urban cluster);*
- *Have fewer than 100 beds;*
- *Have a Medicare provider agreement as a hospital;*
- *Have not had a swing bed approval terminated within the two years previous to submission of the current application for swing bed approval;*
- *Not have a nursing waiver granted as specified in the "Code of Federal Regulations" (CFR) at 42 CFR 482.66(b)(1-8);*
- *Be substantially in compliance with the following SNF participation requirements as specified at 42 CFR 482.66(b)(1-8):*
  - *Residents' rights;*
  - *Admission, transfer, and discharge rights;*

Service Area Nursing Home Utilization-2011										
Facility	Licensed Beds	SNF Beds-Medicare	SNF/NF Beds-Dually Certified	NF Beds-Medicaid	Licensed Only Beds Non-Certified	SNF Medicare ADC	SNF Medicaid ADC	SNF All other Payors ADC	NF ADC	Total ADC

<b>TOTAL</b>									

**Six County  
Service Area Utilization Trends (2009-2011)**

Facility	Licensed Beds	2009 Patient Days	2010 Patient Days	2011 Patient Days	'09- '11 % change	2009 % Occupancy	2010 % Occupancy	2011 % Occupancy
<b>TOTAL</b>								

**12. Section C, Need, Item 6**

Please calculate the hospital's licensed and staffed bed occupancy rates for the past three years by the following two methods: 1) for all 85 licensed beds, and 2) for the 75 medical/surgical beds

***Occupancy Rates – Please note that the Geri-Psych unit was not implemented until 2010, so all 85 beds were Medical/Surgical beds in 2009.***

**Licensed Bed Occupancy Rates:**

***2009 – 24% occupancy rate (all 85 beds)***

***2010 – 21% occupancy rate for 85 beds. 24% occupancy rate for 75 medical/surgical beds.***

***2011 – 20% occupancy rate for 85 beds. 22% occupancy rate for 75 medical/surgical beds.***

**Staffed Bed Occupancy Rates:**

***2009 – 38% occupancy rate***

***2010 – 36% occupancy rate for 85 beds. 39% occupancy rate for 75 medical/surgical beds.***

***2011 – 34% occupancy rate for 85 beds. 36% occupancy rate for 75 medical/surgical beds.***

Please complete the following table:

**HMA Fentress dba Jamestown Regional Medical Center  
Projected Swing Bed Utilization**

Year	Licensed Beds	*Medicare-certified beds	SNF Medicare ADC	SNF Medicaid ADC	SNF All other Payors ADC	NF ADC	Total ADC	Licensed Occupancy %
1	6	6	4	1.3			5.3	88.3%
2	6	6	4.1	1.4			5.5	91.6%

\* Includes dually-certified beds

The applicant indicates that all patient days will be Level II days. What will happen to Medicaid patients who no longer require care to justify Level II reimbursement?

*Jamestown RMC's swing bed services will be for the purposes of caring for patients who need Level II skilled nursing care. When any patient no longer requires Level II care, he or she will be discharged into a more appropriate care setting. As discussed previously, at discharge, a Nurse (along with the entire patient care team) will assist the patient by providing appropriate discharge planning, including connecting the patient with necessary social services.*

**13. Section C, Economic Feasibility, Item 1**

Since the Department of Health's Board for Licensing Health Care Facilities adopted the 2010 Edition of the AIA Guidelines recently, please discuss how the project will pass the Department of Health's Board for Licensing Health Care Facilities' survey inspection for occupancy as skilled nursing beds.

*The beds that will be utilized in this project are existing Medical/Surgical beds in the Jamestown Regional Medical Center nursing units. The hospital has recently undergone surveys in which it passed the requirements for hospital facilities, which are more stringent than the requirements for skilled beds.*

**14. Section C, Economic Feasibility, Item 4 (Historical and Projected Data Chart)**

Please clarify why salaries and wages have decreased from \$10,039,123 in 2009 to \$8,996,114 in 2011 on the Historical Data Chart while revenue for outpatient and inpatient services have increased during the same time period.

*The hospital went through a reduction in staff during 2011, reducing the costs for both salaries and benefits, which is reflected in the salaries and wages line of the Historical Data Chart. Revenues for inpatient and outpatient services increased due to two charge increases over the three year period.*

The categories of D.9 Operating Expenses in the Historical Data chart for 2009-2011 on a separate page is noted. Since these expenses range from \$5,157,418 to \$7,508,379,

please itemize those expenses to the categories listed by the applicant i.e.- Repairs and Maintenance, Travel, Training, Meals, Dues and Subscriptions, Memberships, Recruitment.

***An itemization of D.9 Operating Expenses has been included on the updated Historical Data Chart, shown in Attachment 14.A.***

Please note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should also include any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees should not include expense allocations for support services, e.g., finance, human resources, information technology, legal, managed care, planning marketing, quality assurance, etc. that have been consolidated/centralized for the subsidiaries of a parent company. The HSDA is utilizing more detailed Historical and Projected Data Charts. If needed, please complete a revised Projected Data Chart.

***A revised Historical Data Chart has been attached to more accurately categorize management fees, Attachment 14.A. The most recent format of the Historical Data Chart was used. No Management Fees were projected in the original Projected Data Chart, so no revision is needed.***

The applicant has experienced net operating losses in 2009-2011. Please provide a projected data chart for HMA Fentress dba/Jamestown Regional Medical Center for two years following completion of the proposed project.

***A projected data chart for HMA Fentress County General Hospital d/b/a Jamestown Regional Medical Center for two years following completion of the project is attached as Attachment 14.B.***

The applicant is assigning \$20,000 to Physician's Salaries and Wages which calculates to \$1,666 per month for physician's services. Please clarify if this amount is sufficient while the applicant is projecting a 90% occupancy rate in Year One.

***The \$20,000 projected as "Physician's Salaries and Wages" is actually the Medical Director fee. \$20,000 has been determined to be fair market value for Medical Director services for the skilled nursing beds according to the most recent MGMA Medical Director compensation data. The physicians providing patient care bill for the professional component of their services, and are not paid a salary by the hospital.***

The applicant has assigned \$753,650 to salaries in Year One and \$799,836 in Year Two of the project. Please provide details regarding how these figures were calculated.

*The salary assumptions made to support the staffing needed for an average daily census of 5.3 patients is one (1) RN, one (1) LPN, and one (1) CNA at all times, 24 hours per day, seven days per week. Going from Year One to Year Two, a 3% salary increase was projected, along with an increase in the cost of benefits.*

**15. Section C, Economic Feasibility, Item 9**

As was noted earlier it is unclear how the applicant expects to serve only skilled patients as some Medicaid patients will at some point in their stay only require NF care. Please discuss.

*Jamestown Regional Medical Center's swing bed services will be for the purposes of caring for patients who need Level II skilled nursing care. When any patient no longer requires Level II care, he or she will be discharged into a more appropriate care setting.*

**16. Section C, Orderly Development, Item 3**

The applicant states earlier in the application Occupational therapy will be provided by a part-time therapist. Please clarify if the applicant plans to hire an Occupational Therapist.

*Yes, the applicant intends to hire an Occupational Therapist on a part-time basis.*

Please clarify if the existing staff is trained to provide skilled nursing services.

*The existing staff is qualified to provide skilled nursing services and to meet the needs of the skilled nursing patients. If this application is approved, general staff training will be provided, ensuring that staff members are fully aware of the differences in expectation for skilled nursing patients versus acute care patients, as well as the accommodations that should be made to help those patients gain greater independence.*

**17. Section C, Orderly Development, Item 7 (a).**

Please verify that the applicant has reviewed and understand licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or applicable Medicare requirements.

*The applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and applicable Medicare requirements.*

**18. Project Completion Chart**

Since this application will not be heard any sooner than February 2012, please make the appropriate adjustments and submit a revised Project Completion Forecast Chart.

*An updated Project Completion Forecast Chart is attached as Attachment 18.*

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60<sup>th</sup>) day after written notification is Tuesday, January 15, 2013. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

- (1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.
- (2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Phillip Earhart  
Health Services Development Examiner

Ms. Melanie B. Robinson  
November 21, 2012  
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SUPPLEMENTAL

Enclosure

PME

List of Attachments

Attachment 1	Certificate of Existence
Attachment 3	Property Ownership Documents
Attachment 4	CMS Fact Sheet regarding Swing Bed Services
Attachment 7	Floor Plan
Attachment 11	Utilization Charts
Attachment 14.A	Updated Historical Data Chart with Other Expense Detail
Attachment 14.B	Projected Data Chart for Jamestown Regional Medical Center
Attachment 18	Project Completion Forecast Chart

## **Attachment 1**



**Department of State**  
Corporate Filings  
312 Eighth Avenue North  
6<sup>th</sup> Floor, William R. Snodgrass Tower  
Nashville, TN 37243

**CERTIFICATE OF CONVERSION**  
(Domestic For-Profit Corporation into LLC  
under TCA §48-21-111)

(For use on or after 7/1/2006)

For Office Use Only

Pursuant to the provisions of §48-21-111 of the Tennessee Business Corporation Act and §48-249-703 of the Tennessee Revised Limited Liability Company Act, the undersigned hereby submits this certificate of conversion:

1. The name and principal business address of the converting domestic corporation is:  
HMA Fentress County General Hospital, Inc.  
5811 Pelican Bay Blvd., Suite 500  
Naples, FL 34108
2. The converting corporation was formed in Tennessee, its date of formation is APRIL 29, 2009 (month/day/year), and its SOS control number (if known) is: 0601484
3. The converting corporation is being converted to a domestic limited liability company, and the name of the domestic limited liability company as set forth in its article of organization is: HMA Fentress County General Hospital, LLC
4. The plan of conversion is attached to this certificate of conversion and is incorporated herein by reference.
5. The terms and conditions of the conversion have been approved by the unanimous vote of the shareholders; all required approvals of the conversion have been obtained by the converting corporation.
6. The number of members of the limited liability company at the date of conversion is one (1).
7. If the conversion is not to be effective upon the filing of the certificate of conversion and articles of organization, then the future effective date and time of the conversion is:  
Date: Effective upon filing, Time: \_\_\_\_\_

MAY 1, 2009  
Signature Date

Timothy R. Parry  
Signature

Senior Vice President  
Signer's Capacity (if other than individual capacity)

Timothy R. Parry  
Name (printed or typed)

**PLAN OF CONVERSION**  
**OF**  
**HMA FENTRESS COUNTY GENERAL HOSPITAL, INC.**

This Plan of Conversion (the "Plan") is made pursuant to Section 48-21-111 of the Tennessee Business Corporation Act and Section 48-249-703 of the Tennessee Revised Limited Liability Company Act to convert **HMA FENTRESS COUNTY GENERAL HOSPITAL, INC.**, a Tennessee corporation (the "Converting Entity") to a Tennessee limited liability company under the name "**HMA FENTRESS COUNTY GENERAL HOSPITAL, LLC**" (the "Converted Entity"), and shall be effective only upon its due approval and authorization by the unanimous written consent of the holders of all outstanding shares of the capital stock of the Converting Entity.

1. The name of the Converting Entity is HMA Fentress County General Hospital, Inc., a Tennessee corporation, and the name of the Converted Entity is HMA Fentress County General Hospital, LLC, a Tennessee limited liability company.
2. All of the issued and outstanding shares of the Converting Entity are owned by Health Management Associates, Inc. and represent a 100% ownership interest in the Converting Entity. Upon the filing of the Articles of Conversion for the Converting Entity, such 100% ownership of the Converting Entity by Health Management Associates, Inc. shall be converted into a 100% membership interest in the Converted Entity.
3. Subject to the approval and adoption of this Plan by the shareholders and Board of Directors of the Converting Entity, the conversion will become effective upon the filing of the Articles of Conversion with the Tennessee Secretary of State.
4. A true and correct copy of the Articles of Organization of the Converted Entity is attached hereto as Exhibit A.
5. Notification of the approval of the conversion will be deemed to be execution of the Operating Agreement by the members of the Converted Entity.

**EXHIBIT A**

**ARTICLES OF ORGANIZATION  
OF  
HMA FENTRESS COUNTY GENERAL HOSPITAL, LLC**

State of Tennessee



Department of State  
Corporate Filings  
312 Eighth Avenue North  
6<sup>th</sup> Floor, William R. Snodgrass Tower  
Nashville, TN 37243

ARTICLES OF ORGANIZATION  
(LIMITED LIABILITY COMPANY)

(For use on or after 7/1/2006)

For Office Use Only

The Articles of Organization presented herein are adopted in accordance with the provisions of the Tennessee Revised Limited Liability Company Act.

1. The name of the Limited Liability Company is: HMA Fentress County General Hospital, LLC

(NOTE: Pursuant to the provisions of TCA §48-249-106, each limited Liability Company name must contain the words "Limited Liability Company" or the abbreviation "LLC" or "L.L.C.")

2. The name and complete address of the Limited Liability Company's initial registered agent and office located in the state of Tennessee is:

C T Corporation System

(Name)

800 S. Gay Street, Suite 2021

Knoxville

TN 37929

(Street address)

(City)

(State/Zip Code)

Knoxville

(County)

3. The Limited Liability Company will be: (NOTE: PLEASE MARK APPLICABLE BOX)

☐ Member Managed

☒ Manager Managed

☐ Director Managed

4. Number of Members at the date of filing, if more than six (6): one (1)

5. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time is: (Not to exceed 90 days)

Date: Upon Filing, Time: \_\_\_\_\_

6. The complete address of the Limited Liability Company's principal executive office is:

5811 Pelican Bay Blvd., Suite 500, Naples, FL 34108-2710

(Street Address)

(City)

(State/County/Zip Code)

7. Period of Duration if not perpetual: Perpetual

8. Other Provisions:

9. THIS COMPANY IS A NONPROFIT LIMITED LIABILITY COMPANY (Check if applicable) ☐

MAY 1, 2009

Signature Date

Timothy R. Parry

Signature

Senior Vice President of Sole Member

Signer's Capacity (if other than individual capacity)

Timothy R. Parry

Name (printed or typed)

**Attachment 3**

**Description of Property Ownership Documents that Follow:** 2012 NOV 26 AM 9:33

- **Order of Default Judgment, dated November 13, 2012, quieting title in favor of HMA Fentress County General Hospital LLC for Parcel 1 (.57 acres) and Parcel 2 (1.49 acres).**
- **Deed for Parcel 3 (2.95 acres), dated December 21, 2001, from Paracelsus Real Estate Corporation to Paracelsus Fentress County General Hospital, Inc.**
- **Certificate of Amendment of Articles of Incorporation of Paracelsus Fentress County General Hospital, Inc., dated January 23, 2002, changing name of Paracelsus Fentress County General Hospital, Inc. to HMA Fentress County General Hospital, Inc.**
- **Certificate of Conversion, dated May 1, 2009, converting HMA Fentress County General Hospital, Inc., to HMA Fentress County General Hospital LLC.**
- **Deed for Parcel 4 (2.42 acres), dated July 24, 2003, from Mark and Sarah Clapp to HMA Fentress County General Hospital Inc.**

IN THE CHANCERY COURT FOR THE STATE OF TENNESSEE  
EIGHTH JUDICIAL DISTRICT  
AT JAMESTOWN

HMA FENTRESS COUNTY GENERAL  
HOSPITAL, LLC,

Plaintiff,

v.

PARACELSUS REAL ESTATE  
CORPORATION and CLARENT HOSPITAL  
CORPORATION, f/k/a/ PARACELSUS  
HEALTHCARE CORPORATION,

Defendants.

Filed: 13<sup>th</sup> day of Nov. 2012

Time 10:26 A.M.

Kathryn R. Taylor: Clerk & Master

Case No. 12-25

**RULE 58 NOTIFICATION  
REQUESTED**

I do hereby certify this to be a true and  
correct copy of the original Order

In case # 12-25

Kathryn R. Taylor, Clerk & Master

**ORDER OF DEFAULT JUDGMENT**

This cause came to be heard on November 13, 2012, upon Plaintiff HMA Fentress County General Hospital, LLC's Motion for Default Judgment against defendants Paracelsus Real Estate Corporation and Clarent Hospital Corporation, f/k/a Paracelsus Healthcare Corporation ("Defendants"), pursuant to Rule 55. It appearing to the Court that the Complaint was filed in this Court on June 29, 2012; that the Summons and Complaint were duly served on Defendants via the Secretary of State on July 16, 2012; that no answer or other defense has been filed by Defendants; and that the relief requested should be granted;

**IT IS, THEREFORE, ORDERED, ADJUDGED, AND DECREED:**

- a. Plaintiff HMA Fentress County General Hospital, LLC is the owner in fee simple of the .57 acre parcel, including any improvements thereon, as further described in the Complaint as "Parcel 1," that was previously held by

Paracelsus Real Estate Corporation by deed of record in Book X6, Page 669,

Fentress County Register's Office and more fully described below:

Lying and being in the First Civil District of Fentress County, Tennessee, and within the corporate limits of the City of Jamestown, approximately one-half (1/2) mile west of the Courthouse via Tennessee State Highway 52 and Duncan Street, and beginning at an iron pin in the East right of way of Duncan Street, same being the Northwest corner of the Fentress County General Hospital tract; South 70 degrees 23' East 117.54 feet to an iron pin; thence North 22 degrees 40' East 121.10 feet to an iron pin; thence South 67 degrees 60' east 8.02 feet to an iron pin; thence North 13 degrees 08' East 44.04 feet to an iron pin; thence North 78 degrees 25' West 101.50 feet to an iron pin; thence North 05 minutes 17' East 63.23 feet to an iron pin; thence North 81 degree 09' West 58.21 feet to an iron pin in the East right of way of Duncan street; thence with the East right of way of Duncan Street South 07 degrees 53' West 205.12 feet to the beginning corner, containing 0.57 of an acre, more or less, as shown on the survey of Rodney W. Foy, Tennessee Registered Land Surveyor No. 730, a copy of which is attached hereto for more complete description.

Being the same property conveyed to Jamestown Internal Medicine Group by deed from Fentress County, Tennessee of record in Book C, Series 6, Page 659, said Register's Office.

- b. Paracelsus Real Estate Corporation has no right, title, estate, interest in or lien on Parcel 1;
- c. Plaintiff HMA Fentress County General Hospital, LLC is the owner in fee simple of the 1.49 acre parcel, including any improvements thereon, as further described in the Complaint as "Parcel 2," that was previously held by Paracelsus Healthcare Corporation by deed of record in Book K7, Page 417,

Fentress County Register's Office and more fully described below:

Lying and being in the First Civil District and located approximately 3/4th of a mile west of the Courthouse in

Jamestown, Tennessee, via of Tennessee Highway 52 and beginning at an iron pin on the north side of Tennessee Highway 52 and beginning at an iron pin on the north side of Tennessee Highway 52 at the southwest corner of the Burden Drug Center property in the beginning point as described in the deed from Baz Broadcasting Company, Inc., a/k/a Baz Broadcasting, Inc. unto Mark A. Clapp and wife, Sarah H. Clapp, as recorded in Deed Book G-7, Page 479 of the Register's Office of Fentress County, Tennessee, at an iron pin; thence running with the north margin of Tennessee Highway 52 north 66 degrees 56' west 99.76 feet to an iron pin and running thence northwardly with the east line the Fentress County Hospital property, north 08 degrees 47' east 626.01 feet to a steel post, being the southeastern portion utilized by the Fentress County Ambulance Service; thence north 81 degrees 47' west 99.71 feet to a steel post; thence south 08 degrees 14' 465.65 feet to an iron pin being the northwestern corner of that tract or parcel of land conveyed by Baz Broadcasting Company, Inc., unto Burden Drug Center, Inc., as recorded in Deed Book C-7, Page 247 of the Register's Office of Fentress County, Tennessee; thence with the wet line of said Burden Drug Center property south 11 degrees 06' west 186.13 feet to the beginning corner, containing 1.49 acres, more or less, as shown by the Plat of Rodney W. Foy, Tennessee Registered Surveyor #730, attached as an exhibit to the Deed recorded in Deed Book G-7, Page 479 of the Register's Office of Fentress County, Tennessee.

- d. Paracelsus Healthcare Corporation has no right, title, estate, interest in or lien on Parcel 2;
- e. Clarent Hospital Corporation is liable for breach of contract due to its failure to transfer title to the above-described .57 acre and 1.49 acre parcels to HMA Fentress County General Hospital, LLC, pursuant to Section 5.11 of the Stock Purchase Agreement entered into between Clarent Hospital Corporation and Health Management Associates on November 7, 2001; and
- f. Courts costs are taxed to Defendants, who both share a last known address of 515 West Greens Road, Suite 500, Houston, Texas 77067.

ENTERED this 13 day of November, 2012.

Submitted for Entry:

C. David Killion

Joshua R. Denton, BPR# 23248  
 C. David Killion, BPR # 26412  
 BASS, BERRY & SIMS PLC  
 150 3rd Avenue South, Suite 2800  
 Nashville, Tennessee 37201  
 Ofc: 615-742-7718  
 Fax: 615-742-0414  
 Email: dkillion@bassberry.com  
*Attorneys for Plaintiff*

**CERTIFICATE OF SERVICE**

I hereby certify that a true and correct copy of the foregoing has been served on the following by depositing the same into the United States Mail, first class postage prepaid, on this the 9<sup>th</sup> day of November, 2012.

Paracelsus Real Estate Corporation  
 515 West Greens Road, Suite 500  
 Houston, Texas 77067

Clarent Hospital Corporation  
 515 West Greens Road, Suite 500  
 Houston, Texas 77067

C. David Killion

11067152.1

Address New Owner:	Send Tax Bills to:	Map-Parcel Numbers
Paracelsus Fentress County General Hospital, Inc. 436 Central Avenue West P.O. Box 1500 Jamestown, TN 38556	Paracelsus Fentress County General Hospital, Inc. 436 Central Avenue West P.O. Box 1500 Jamestown, TN 38556	Map 53P; GP A; CTL/ MAP 10.01
This instrument prepared by: Kimberley Elting, Jones, Day, Reavis & Pogue, 2727 North Harwood Street, Dallas, Texas 75201		

QUITCLAIM DEED

FOR VALUABLE CONSIDERATION, the receipt and sufficiency of which are acknowledged, PARACELSUS REAL ESTATE CORPORATION, a California corporation ("Grantor") hereby sells and quitclaims to PARACELSUS FENTRESS COUNTY GENERAL HOSPITAL, INC., a California corporation ("Grantee"), its successors and assigns, all of Grantor's right, title and interest in and to certain land in Fentress County, Tennessee, being more particularly described in Exhibit A attached hereto and incorporated herein by reference (the "Property").

This conveyance of Grantor's interest in the Property is made expressly subject to all limitations, restrictions, and encumbrances as may affect the Property.

Executed as of 8:00 a.m. this 21st day of December, 2001.

STATE OF TEXAS  
COUNTY OF HARRIS

I swear or affirm to the best of Affiant's knowledge, information and belief, the actual consideration for this transfer is \$10.00.

  
Affiant

Subscribed and sworn to before me, this the 21<sup>st</sup> day of December 2001.



  
NOTARY PUBLIC

My Commission Expires: 8/8/02

Inst # 2001622501-LR year: 2001  
Book 22 Page 849

This is improved property, known as Fentress County General Hospital.

PARACELTUS REAL ESTATE  
CORPORATION, a California corporation

By: [Signature]  
Title: Vice President & Asst. Secretary

STATE OF TEXAS )  
COUNTY OF HARRIS )

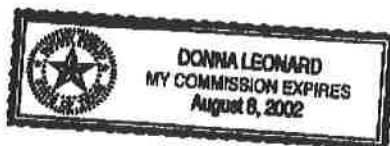
Before me, Donna Leonard, the undersigned, a Notary Public in and for the County and State aforesaid, personally appeared Lawrence A. Murphy with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself/herself to be the Vice President and Assistant Secretary of Paracelsus Real Estate Corporation, the within named bargainor, a corporation, and that he/she as such VP & Assistant Secretary, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by himself/herself as such VP & Assistant Secretary.

WITNESS my hand and seal at office in Houston, TEXAS, this the 21<sup>st</sup> day of December, 2001.

Donna Leonard  
Notary Public

My Commission Expires:

8/8/02



Inst # 2001622501-LR year: 2001  
Book 22 Page 850

Property Address:  
436 Central Avenue West  
P.O. Box 1500  
Jamestown, TN 38556

**EXHIBIT A****Legal Description**

LYING and BEING in the First (1<sup>st</sup>) Civil District of Fentress County, Tennessee, and within the corporate limits of the City of Jamestown and being a part, parcel and portion of the lands conveyed by P. G. Crooks to Fentress County, Tennessee, by deed of conveyance dated February 10, 1985, as recorded in Deed Book Z-3, page 366, in the Fentress County Register's Office, and being more particularly described as follows:

BEGINNING at a point, a nail in the pavement which is situated in the North margin or right-of-way of Tennessee State Highway 52, which point is located South 68 deg. 24 min. East, 282.41 feet from the intersection of said Highway 52 and Duncan Street, and is also situated North 64 deg. 57 min. West, 77.32 feet from the Southwest corner of Turk Baz; thence North 10 deg. 46 min. East, 368.31 feet to a nail in the pavement; thence North 12 deg. 00 min. East, 213.60 feet to a nail in the pavement; thence North 78 deg. 31 min. West, 132.15 feet to an iron pin; thence South 19 deg. 35 min. West, 124.53 feet to an iron pin; thence North 67 deg. 14 min. West, 7.95 feet to an iron pin; thence South 23 deg. 11 min. West, 121.17 feet to an iron pin; thence North 69 deg. 57 min. West, 117.41 feet to an iron pin situated in the East margin or right-of-way of Duncan Street; thence with the East margin and right-of-way of Duncan Street, South 7 deg. 16 min. West, 310.32 feet to the intersection of Duncan Street and Tennessee State Highway 52; thence South 68 deg. 24 min. East, 282.41 feet to the point of BEGINNING, and containing 2.95 acres.

**END OF LEGAL DESCRIPTION**

Source of Title: Warranty Book H, Series 6, Page 311

FENTRESS COUNTY, TENNESSEE  
 Receipt # :25592  
 01:52 PM, On December 27, 2001  
 Recorded in Book 22 Pages 849 - 851  
 State Tax \$ 0.00 Register \$ 0.00  
 Recording \$ 15.00 DPFE \$ 2.00  
 TOTAL RECORDING AMOUNT \$ 17.00  
 Register Of Deeds : L. FAYE STEPHENS  
 Deputy Register : MARTI REKROAT  
 Inst # 2001622501-LR year: 2001  
 Book 22 Page 851

AD576188

1262515

CERTIFICATE OF AMENDMENT

OF

ARTICLES OF INCORPORATION

OF

PARACELUS FENTRESS COUNTY GENERAL HOSPITAL, INC.

\* \* \* \* \*

We, Joseph V. Vumbacco, Chief Executive Officer, and Timothy R. Parry, Senior Vice President and Secretary, of Paracelsus Fentress County General Hospital, Inc., a corporation duly organized and existing under the laws of the State of California, do hereby certify:

1. That they are the Chief Executive Officer and Senior Vice President and Secretary, respectively, of Paracelsus Fentress County General Hospital, Inc., a California corporation.
2. That an amendment to the Articles of Incorporation of this corporation has been approved by the board of directors.
3. The amendment so approved by the board of directors is as follows:

Article I of the Articles of Incorporation of this corporation is amended to read as follows:


"The name of this corporation is HMA FENTRESS COUNTY GENERAL HOSPITAL, INC."


4. That the shareholders have adopted said amendment by written consent. That the wording of said amendment as approved by written consent of the shareholders is the same as that set forth above. That said written consent was signed by the sole shareholder in accordance with Section 902 of the California Corporation Code.
5. That this certificate shall become effective on the date of filing.

Each of the undersigned declares under penalty of perjury under the laws of the State of California that the statements contained in the foregoing certificate are true of their own knowledge.

**FILED** *DMR*  
In the Office of the Secretary of State  
of the State of California  
JAN 29 2002  
*Bill Jones*  
BILL JONES, Secretary of State

Executed at Naples, Florida on January 23, 2002.

  
Joseph V. Vumbacco, Chief Executive  
Officer

  
Timothy R. Parry, Senior Vice President and  
Secretary

BK/PG:117/777-781

07001357

5 PGS : AL - ARTICLES OF INCORPORATIO	
TRIM BATCH: 11226	
03/26/2007 - 10:26:37 AM	
VALUE	0.00
MORTGAGE TAX	0.00
TRANSFER TAX	0.00
RECORDING FEE	25.00
OP FEE	2.00
REGISTER'S FEE	0.00
TOTAL AMOUNT	27.00

STATE OF TENNESSEE, FENTRESS COUNTY

FAYE STEPHENS  
DEPUTY CLERK



2012 NOV 26 AM 9:33

19

State of Tennessee



Department of State  
Corporate Filings  
312 Eighth Avenue North  
6<sup>th</sup> Floor, William R. Snodgrass Tower  
Nashville, TN 37243

**CERTIFICATE OF CONVERSION**  
(Domestic For-Profit Corporation into LLC  
under TCA §48-21-111)

(For use on or after 7/1/2006)

For Office Use Only

RECEIVED  
STATE OF TENNESSEE  
SECRETARY OF STATE  
MAY - 4 AM 11:4

Pursuant to the provisions of §48-21-111 of the Tennessee Business Corporation Act and §48-249-703 of the Tennessee Revised Limited Liability Company Act, the undersigned hereby submits this certificate of conversion:

1. The name and principal business address of the converting domestic corporation is:

HMA Fentress County General Hospital, Inc.

5811 Pelican Bay Blvd., Suite 500

Naples, FL 34108

2. The converting corporation was formed in Tennessee, its date of formation is APRIL 29, 2009 (month/day/year), and its SOS control number (if known) is: 0601484

3. The converting corporation is being converted to a domestic limited liability company, and the name of the domestic limited liability company as set forth in its article of organization is: HMA Fentress County General Hospital, LLC

4. The plan of conversion is attached to this certificate of conversion and is incorporated herein by reference.

5. The terms and conditions of the conversion have been approved by the unanimous vote of the shareholders; all required approvals of the conversion have been obtained by the converting corporation.

6. The number of members of the limited liability company at the date of conversion is one (1)

7. If the conversion is not to be effective upon the filing of the certificate of conversion and articles of organization, then the future effective date and time of the conversion is:

Date: Effective upon filing, Time: \_\_\_\_\_

MAY 1, 2009

Signature Date

Signature

Timothy R. Parry

Senior Vice President

Signer's Capacity (if other than individual capacity)

Name (printed or typed)

SS-4498 (Rev. 05/06)

Filing Fee \$20

RDA 2458

## PLAN OF CONVERSION

OF

## HMA FENTRESS COUNTY GENERAL HOSPITAL, INC.

RECEIVED  
STATE OF TENNESSEE  
2009 MAY -4 AM 11:50  
THE HONORABLE  
SECRETARY OF STATE

6529.2205

This Plan of Conversion (the "Plan") is made pursuant to Section 48-21-111 of the Tennessee Business Corporation Act and Section 48-249-703 of the Tennessee Revised Limited Liability Company Act to convert HMA FENTRESS COUNTY GENERAL HOSPITAL, INC., a Tennessee corporation (the "Converting Entity") to a Tennessee limited liability company under the name "HMA FENTRESS COUNTY GENERAL HOSPITAL, LLC" (the "Converted Entity"), and shall be effective only upon its due approval and authorization by the unanimous written consent of the holders of all outstanding shares of the capital stock of the Converting Entity.

1. The name of the Converting Entity is HMA Fentress County General Hospital, Inc., a Tennessee corporation, and the name of the Converted Entity is HMA Fentress County General Hospital, LLC, a Tennessee limited liability company.
2. All of the issued and outstanding shares of the Converting Entity are owned by Health Management Associates, Inc. and represent a 100% ownership interest in the Converting Entity. Upon the filing of the Articles of Conversion for the Converting Entity, such 100% ownership of the Converting Entity by Health Management Associates, Inc. shall be converted into a 100% membership interest in the Converted Entity.
3. Subject to the approval and adoption of this Plan by the shareholders and Board of Directors of the Converting Entity, the conversion will become effective upon the filing of the Articles of Conversion with the Tennessee Secretary of State.
4. A true and correct copy of the Articles of Organization of the Converted Entity is attached hereto as Exhibit A.
5. Notification of the approval of the conversion will be deemed to be execution of the Operating Agreement by the members of the Converted Entity.



6529.2206

RECEIVED  
STATE OF TENNESSEE

2009 MAY -4 AM 11:50

THE COMPTROLLER  
SECRETARY OF STATE

**EXHIBIT A**  
**ARTICLES OF ORGANIZATION**  
**OF**  
**HMA FENTRESS COUNTY GENERAL HOSPITAL, LLC**

 <b>State of Tennessee</b> <b>Department of State</b> Corporate Filings 312 Eighth Avenue North 6 <sup>th</sup> Floor, William R. Snodgrass Tower Nashville, TN 37243	<b>ARTICLES OF ORGANIZATION</b> <b>(LIMITED LIABILITY COMPANY)</b>  (For use on or after 7/1/2006)	For Office Use Only RECEIVED MAY -4 AM 11:49 THE SECRETARY OF STATE STATE OF TENNESSEE
The Articles of Organization presented herein are adopted in accordance with the provisions of the Tennessee Revised Limited Liability Company Act.		
1. The name of the Limited Liability Company is: _____ HMA Fentress County General Hospital, LLC (NOTE: Pursuant to the provisions of TCA §48-249-106, each limited liability company name must contain the words "Limited Liability Company" or the abbreviation "LLC" or "L.L.C.")		
2. The name and complete address of the Limited Liability Company's initial registered agent and office located in the state of Tennessee is: C T Corporation System (Name) _____ 800 S. Gay Street, Suite 2021                      Knoxville                      TN 37929 (Street address)    (City)    (State / Zip Code) Knoxville (County)		
3. The Limited Liability Company will be: (NOTE: PLEASE MARK APPLICABLE BOX) <input type="checkbox"/> Member Managed <input checked="" type="checkbox"/> Manager Managed <input type="checkbox"/> Director Managed		
4. Number of Members at the date of filing, if more than six (6): one (1)		
5. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time is: (Not to exceed 90 days) Date: Upon Filing                      ,                      Time:		
6. The complete address of the Limited Liability Company's principal executive office is: 5811 Pelican Bay Blvd., Suite 500, Naples, FL 34108-2710 (Street Address)    (City)    (State / County / Zip Code)		
7. Period of Duration if not perpetual: Perpetual		
8. Other Provisions:		
9. THIS COMPANY IS A NONPROFIT LIMITED LIABILITY COMPANY (Check if applicable) <input type="checkbox"/>		
MAY 1, 2009 Signature Date		 Signature
Senior Vice President of Sole Member Signer's Capacity (if other than individual capacity)		Timothy R. Parry Name (printed or typed)


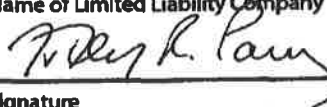
SS-4270 (Rev. 05/06)

Filing Fee: \$50 per member (minimum fee = \$300, maximum fee = \$3,000)

RDA 2-458

0601484

40

<b>State of Tennessee</b>  <b>Department of State</b> Corporate Filings 312 Rosa L. Parks Avenue 6 <sup>th</sup> Floor, William R. Snodgrass Tower Nashville, TN 37243	<div style="text-align: center;">           RECEIVED            STATE OF TENNESSEE            APPLICATION FOR REGISTRATION            2009 JUN 16 AM 9:40  <b>ASSUMED</b>  <b>LIMITED LIABILITY COMPANY NAME</b>            THE HANCOCK            SECRETARY OF STATE         </div>	<div style="text-align: center;">           RECEIVED            STATE OF TENNESSEE            2009 JUN 12 PM 12:13            THE HANCOCK            SECRETARY OF STATE         </div>
Pursuant to the provisions of §48-207-101 (d) of the Tennessee Limited Liability Company Act or §48-249-106(d) of the Tennessee Revised Limited Liability Company Act, the undersigned Limited Liability Company hereby submits this application:		
1. The true name of the Limited Liability Company is: <u>HMA Fentress County General Hospital, LLC</u>		
2. The state or country of organization is: <u>Tennessee</u>		
3. The Limited Liability Company intends to transact business under an assumed Limited Liability Company name.		
4. The assumed Limited Liability Company name the Limited Liability Company proposes to use is: <u>Jamestown Regional Medical Center</u>		
<b>NOTE: The assumed Limited Liability Company name must meet the requirements of §48-207-101 of the Tennessee Limited Liability Company Act or §48-249-106 of the Tennessee Revised Limited Liability Company Act, as applicable.</b>		
<u>6-1-09</u> Signature Date  Senior VP and Secretary Signer's Capacity	<u>HMA Fentress County General Hospital, LLC</u> Name of Limited Liability Company  Signature <u>Timothy R. Parry</u> Name (typed or printed)	
SS-4230 (Rev. 01/06)      Filing Fee: \$20.00      RDA 2458		

MAP A 53P 11.00  
 GP CTI/MAP PARCEL  
 N/C SPLIT COMB  
 ROGER COMPTON  
 ASSESSOR OF PROPERTY  
 FENTRESS COUNTY  
 JAMESTOWN, TN 38556

Prepared By: James P. Romer  
 Attorney at Law  
 P.O. Box 797  
 Jamestown, TN 38556

GENERAL WARRANTY DEED

For good and valuable consideration received, we, **MARK A. CLAPP, M.D. and wife, SARAH H. CLAPP**, do hereby sell and convey unto **HMA FENTRESS COUNTY GENERAL HOSPITAL, INC. D/B/A JAMESTOWN REGIONAL MEDICAL CENTER**, P. O. Box 1500, Jamestown, Tennessee 38556, the entity responsible for taxes accruing in the future, the following described real estate:

TRACT ONE:

Lying and being in the First Civil District of Fentress County, Tennessee, and on the North side of but not adjacent to Tennessee Highway 52, about 3/4 mile West of the Courthouse in Jamestown, Tennessee, to the southwest corner of the Burden Drug Center property; thence northwardly on a 40 foot right-of-way north 11° 06' east 186.13 feet and Beginning at an iron pin on the east margin of said right-of-way at the northwest corner of the Burden Drug Center property, and running thence with the east margin of the right-of-way north 08° 21' east 466.09 feet to a steel post; thence south 81° 03' east 223.32 feet to a steel post, the northwest corner of the Gertie Davis tract; thence with the west line of the Gertie Davis tract south 08° 45' west 399.33 feet to a stone, the northwest corner of the Duran Qualls tract; thence with the west line of the Qualls tract south 10° 04' west 87.72 feet to an iron pin in the north margin of the Burden Drug Center tract; thence with north line of the Burden Drug Center tract north 75° 33' west 219.07 feet to the beginning corner, and containing 2.42 acres, more or less.

Being a portion of the lands described in a deed from Baz Broadcasting Company, Inc. a/k/a Baz Broadcasting, Inc. to Mark A. Clapp, M.D. and wife, Sarah H. Clapp, dated March 5, 1993, and recorded in Deed Book G-7, Page 479, in the Register's Office of Fentress County, Tennessee.

The bearings and distances are taken from a survey by Foy Survey Company, Drawing No. 4339, dated July 21, 2003, copy attached.

Map 53P, Group A, Parcel 11

TRACT TWO:

A perpetual right-of-way easement 40 feet in width running the entire length of the 1.49 acre tract conveyed in Deed Book K-7, Page 417 (Map 53P, Group A, Parcel 11.02) along the eastern edge of that tract. This easement was retained by Mark A. Clapp and wife, Sarah H. Clapp in Deed Book K-7, Page 417 and is shown on the plat of Foy Survey Company, Drawing No. 4339, dated July 21, 2003.

THE GRANTORS, MARK A. CLAPP, M.D. AND WIFE, SARAH H. CLAPP HEREBY RETAIN FOR THEMSELVES AND THEIR SUCCESSORS A 40 FOOT RIGHT-OF-WAY TO SERVE THE 3.15 ACRE TRACT TO THE NORTH OF THE PROPERTY BEING CONVEYED HEREIN, AND THE PARTIES AGREE THIS EASEMENT MAY BE RELOCATED BY HMA FENTRESS COUNTY GENERAL HOSPITAL, INC. D/B/A JAMESTOWN REGIONAL MEDICAL CENTER OR ITS SUCCESSORS AND ASSIGNS SO AS NOT TO INTERFERE WITH PROPOSED OR FUTURE IMPROVEMENTS. IF MARK A. CLAPP, M.D. AND SARAH H. CLAPP OR THEIR SUCCESSORS COMPLETE A RIGHT-OF-WAY TO THEIR PROPERTY, ITS

STRUCTURE WILL BE IN HARMONY WITH ANY RIGHT-OF-WAYS ESTABLISHED BY HMA OR ITS SUCCESSORS. IF HMA OR ITS SUCCESSORS NEED TO RELOCATE A RIGHT-OF-WAY ALREADY ESTABLISHED BY MARK A. CLAPP, M.D. AND SARAH H. CLAPP OR THEIR SUCCESSORS TO THEIR REMAINING PROPERTY, HMA OR ITS SUCCESSORS WILL RELOCATE AND RECONSTRUCT SAID RIGHT-OF-WAY TO THE 3.15 ACRE TRACT AT THEIR OWN EXPENSE.

TO HAVE AND TO HOLD unto grantee in fee simple. Grantors covenant lawful seizin and possession, right to convey, and that the land is unincumbered, and will warrant and defend the title thereto against all lawful claims. This 24 day of July, 2003.

Mark A. Clapp, M.D.  
MARK A. CLAPP, M.D.

Sarah H. Clapp  
SARAH H. CLAPP

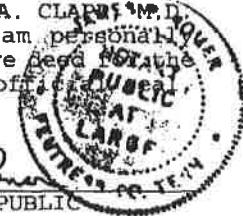
STATE OF TENNESSEE  
COUNTY OF FENTRESS

Before me, the undersigned authority in and for the state and county aforesaid, this day personally appeared MARK A. CLAPP, M.D. and SARAH H. CLAPP, the bargainors, with whom I am personally acquainted and acknowledged the execution of the above deed for the purposes therein contained, as witness my hand and official seal this 23 day of July, 2003.

My Commission expires:

7-20-2004

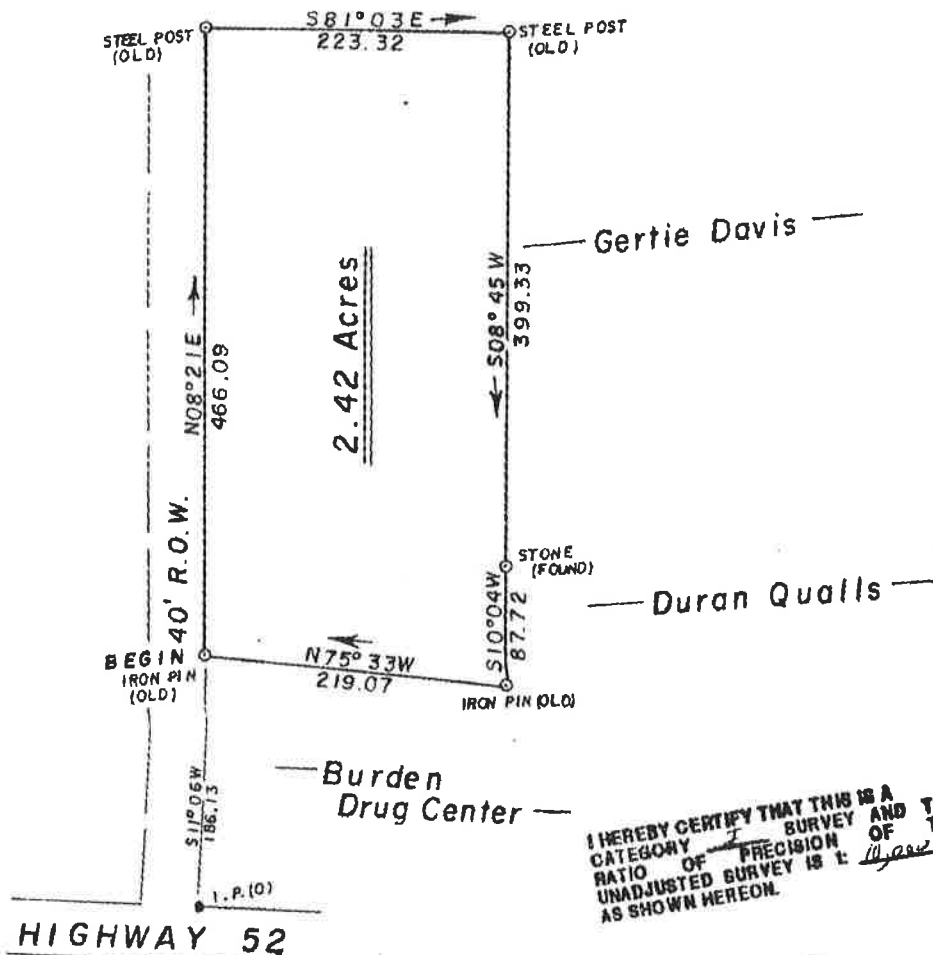
Jane P. Brown  
NOTARY PUBLIC



I or we swear or affirm that the actual consideration for this transfer or value of the property transferred; whichever is greater, is \$ 174,240.00, which amount is equal to or greater than the amount which the property transferred would command at a fair voluntary sale.

Jane P. Brown  
Affiant  
Subscribed and sworn to before me this 24 day of July, 2003.  
Stephane  
Register  
Deputy Register





I HEREBY CERTIFY THAT THIS IS A PRECISION SURVEY AND THE  
CATEGORY I OF THE  
RATIO OF UNADJUSTED SURVEY IS 1: 10,000  
AS SHOWN HEREON.

FOR: H. M. A. FENTRESS COUNTY REGIONAL HOSPITAL  
BEING PARCEL NO. 11 ON TAX MAP NO. 53-P, GROUP "A"

BEING PARCEL NO. 11

FOY SURVEY COMPANY  
JAMESTOWN TENNESSEE

FOR  
SEE ABOVE

FENTRESS CO. TENNESSEE

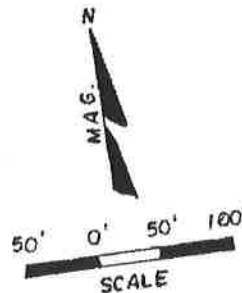
SURVEYED BY: RODNEY W. FOY  
DRAWN BY: GARY M ANDERSON

DATE: 07-21-03 SCALE: 1" = 100'

DWG. NO. 4339

RODNEY W. FOY  
REGISTERED LAND SURVEYOR  
ABR-EXP-11/02

TENNESSEE NO. 730



FENTRESS COUNTY, TENNESSEE  
 Receipt # : 33231  
 08:21 AM, On July 25, 2003  
 Recorded in Book 49 Pages 637 - 639  
 State Tax \$ 644.69 Register \$ 1.00  
 Recordings \$ 15.00 DPFE \$ 2.00  
 TOTAL RECORDING AMOUNT \$ 662.69  
 Register of Deeds : L. FAYE STEPHENS  
 Deputy Register : PATRICIA SLAVEN  
 Inst # 2003265101-LR year: 2003  
 Book 49 Page 639

SUPPLEMENTAL

## **Attachment 4**

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



# Swing Bed Services



## RURAL HEALTH FACT SHEET SERIES

This publication provides the following information about swing bed services:

- ❖ Background;
- ❖ Requirements that apply to hospitals;
- ❖ Requirements that apply to Critical Access Hospitals (CAH);
- ❖ Swing bed services payments; and
- ❖ Resources.

### Background

Hospitals, as defined in Section 1861(e) of the Social Security Act, or CAHs with a Medicare provider agreement that includes Centers for Medicare & Medicaid Services (CMS) approval to furnish swing bed services, may use their beds as needed to furnish either acute or Skilled Nursing Facility (SNF)-level care.

Rural hospitals and CAHs that have swing bed approval increase Medicare beneficiary access to post-acute SNF care and maximize the efficiency of operations by meeting unpredictable demands for acute and long-term care.

Hospitals that are paid under the Acute Care Hospital Inpatient Prospective Payment System (IPPS) and CAHs may use any acute care bed within the hospital or CAH (with the exception of beds within their IPPS excluded rehabilitation or psychiatric unit, beds in an intensive care-type unit, or beds for newborns) for the provision of swing bed services.

Medicare beneficiaries must receive acute care as a hospital or CAH inpatient for a medically necessary

stay of at least three consecutive calendar days in order to qualify for coverage of SNF-level services.

### Requirements That Apply to Hospitals

In order to be granted, and retain, approval to furnish post-acute level SNF care via a swing bed agreement, hospitals must:

- ❖ Be located in a rural area, which includes all areas that are not delineated as urbanized by the U.S. Census Bureau based on the most recent census for which data is published (an urbanized area does not include an urban cluster);
- ❖ Have fewer than 100 beds (excluding beds for newborns and intensive care-type units);
- ❖ Have a Medicare provider agreement as a hospital;
- ❖ Have not had a swing bed approval terminated within the two years previous to submission of the current application for swing bed approval;



- ❖ Not have a nursing waiver granted as specified in the “Code of Federal Regulations” (CFR) at 42 CFR 488.54(c); and
- ❖ Be substantially in compliance with the following SNF participation requirements as specified at 42 CFR 482.66(b)(1–8):
  - Residents’ rights;
  - Admission, transfer, and discharge rights;
  - Resident behavior and facility practices;
  - Patient activities;
  - Social services;
  - Discharge planning;
  - Specialized rehabilitative services; and
  - Dental services.

### Requirements That Apply to Critical Access Hospitals

CAHs must be substantially in compliance with the following SNF participation requirements as specified at 42 CFR 485.645(d)(1–9):

- ❖ Residents’ rights;
- ❖ Admission, transfer, and discharge rights;
- ❖ Resident behavior and facility practices;
- ❖ Patient activities (with exceptions for director of services);
- ❖ Social services;
- ❖ Comprehensive assessment, comprehensive care plan, and discharge planning (with some exceptions);



- ❖ Specialized rehabilitative services;
- ❖ Dental services; and
- ❖ Nutrition.

A CAH may maintain no more than 25 inpatient beds. When a CAH has Medicare approval to furnish swing bed services, it may use any of its 25 inpatient beds for either acute care or SNF-level care. A CAH may also be certified to have an additional 10 beds each in a psychiatric or rehabilitation distinct part unit (DPU); however, a bed that is within a CAH psychiatric or rehabilitation DPU may not be used for swing bed services.

### Swing Bed Services Payments

Effective with cost reporting periods beginning on or after July 1, 2002, hospitals offering swing bed services (excluding CAHs) are paid for their SNF-level services under the SNF PPS. The SNF PPS covers all costs (ancillary, routine, and capital) related to covered services furnished to Medicare beneficiaries under a Medicare Part A covered SNF stay, with the exception of certain specified services that are separately billable under Part B.

CAHs that offer swing bed services are exempt from the SNF PPS and are instead reimbursed for their SNF-level services based on 101 percent of the reasonable cost of the services.

### Resources

For more information about swing bed services, visit [http://www.cms.gov/SNFPSPS/03\\_SwingBed.asp](http://www.cms.gov/SNFPSPS/03_SwingBed.asp) on the CMS website. You may also refer to Chapter 8 of the “Medicare Benefit Policy Manual” (Publication 100-02) and Chapter 6 of the “Medicare Claims Processing Manual” (Publication 100-04) located at <http://www.cms.gov/Manuals/IOM/list.asp> and the “Skilled Nursing Facility” section of the Medicare Learning Network® publication titled “MLN Guided Pathways to Medicare Resources Provider Specific” booklet at [http://www.cms.gov/MLNEdWebGuide/Downloads/Guided\\_Pathways\\_Provider\\_Specific\\_Booklet.pdf](http://www.cms.gov/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf) on the CMS website. For more information about “CFR” citations, refer to the “CFR” located at <http://www.gpo.gov/fdsys/search/home.action> on the U.S. Government Printing Office website. To find the compilation of Social Security laws, visit [http://www.ssa.gov/OP\\_Home/ssact/title18/1800.htm](http://www.ssa.gov/OP_Home/ssact/title18/1800.htm) on the U.S. Social Security Administration website. To find Medicare information for beneficiaries (e.g., Medicare basics, managing health, and resources), visit <http://www.medicare.gov> on the CMS website.

## Helpful Websites

**American Hospital Association Rural Health Care**  
<http://www.aha.org/advocacy-issues/rural>

**Critical Access Hospitals Center**  
<http://www.cms.gov/center/cah.asp>

**Disproportionate Share Hospital**  
[http://www.cms.gov/AcuteInpatientPPS/05\\_dsh.asp](http://www.cms.gov/AcuteInpatientPPS/05_dsh.asp)

**Federally Qualified Health Centers Center**  
<http://www.cms.gov/center/fqhc.asp>

**Health Resources and Services Administration**  
<http://www.hrsa.gov>

**Hospital Center**  
<http://www.cms.gov/center/hospital.asp>

**HPSA/PSA (Physician Bonuses)**  
<http://www.cms.gov/hpsapsaphysicianbonuses>

**Medicare Learning Network**  
<http://www.cms.gov/MLNGenInfo>

**National Association of Community Health Centers**  
<http://www.nachc.org>

**National Association of Rural Health Clinics**  
<http://www.narhc.org>

**National Rural Health Association**  
<http://www.ruralhealthweb.org>

**Rural Health Clinics Center**  
<http://www.cms.gov/center/rural.asp>

**Rural Assistance Center**  
<http://www.raonline.org>

**Swing Bed Providers**  
[http://www.cms.gov/SNFPPS/03\\_SwingBed.asp](http://www.cms.gov/SNFPPS/03_SwingBed.asp)

**Telehealth**  
<http://www.cms.gov/Telehealth>

**U.S. Census Bureau**  
<http://www.census.gov>

## Regional Office Rural Health Coordinators

Below is a list of contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues.

**Region I – Boston**  
**Rick Hoover**  
 E-mail: [rick.hoover@cms.hhs.gov](mailto:rick.hoover@cms.hhs.gov)  
 Telephone: (617) 565-1258  
 States: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

**Region II – New York**  
**Miechal Lefkowitz**  
 E-mail: [miechal.lefkowitz@cms.hhs.gov](mailto:miechal.lefkowitz@cms.hhs.gov)  
 Telephone: (212) 616-2517  
 States: New Jersey, New York, Puerto Rico, and Virgin Islands

**Region III – Philadelphia**  
**Patrick Hamilton**  
 E-mail: [patrick.hamilton@cms.hhs.gov](mailto:patrick.hamilton@cms.hhs.gov)  
 Telephone: (215) 861-4097  
 States: Delaware, Maryland, Pennsylvania, Virginia, West Virginia, and the District of Columbia

**Region IV – Atlanta**  
**Lana Dennis**  
 E-mail: [lane.dennis@cms.hhs.gov](mailto:lane.dennis@cms.hhs.gov)  
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**Region V – Chicago**  
**Christine Davidson**  
 E-mail: [christine.davidson@cms.hhs.gov](mailto:christine.davidson@cms.hhs.gov)  
 Telephone: (312) 886-3642  
 States: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

**Region VI – Dallas**  
**Becky Peal-Sconce**  
 E-mail: [becky.peal-sconce@cms.hhs.gov](mailto:becky.peal-sconce@cms.hhs.gov)  
 Telephone: (214) 767-6444  
 States: Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

**Region VII – Kansas City**  
**Claudia Odgers**  
 E-mail: [claudia.odgers@cms.hhs.gov](mailto:claudia.odgers@cms.hhs.gov)  
 Telephone: (816) 426-6524  
 States: Iowa, Kansas, Missouri, and Nebraska

**Region VIII – Denver**  
**Lyla Nichols**  
 E-mail: [lyla.nichols@cms.hhs.gov](mailto:lyla.nichols@cms.hhs.gov)  
 Telephone: (303) 844-6218  
 States: Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

**Region IX – San Francisco**  
**Neal Logue**  
 E-mail: [neal.logue@cms.hhs.gov](mailto:neal.logue@cms.hhs.gov)  
 Telephone: (415) 744-3551  
 States: Arizona, California, Hawaii, Nevada, Guam, Commonwealth of the Northern Mariana Islands, American Samoa, Marshall Islands, Republic of Palau, and Federated States of Micronesia

**Region X – Seattle**  
**Teresa Cumpton**  
 E-mail: [teresa.cumpton@cms.hhs.gov](mailto:teresa.cumpton@cms.hhs.gov)  
 Telephone: (206) 615-2391  
 States: Alaska, Idaho, Oregon, and Washington



This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

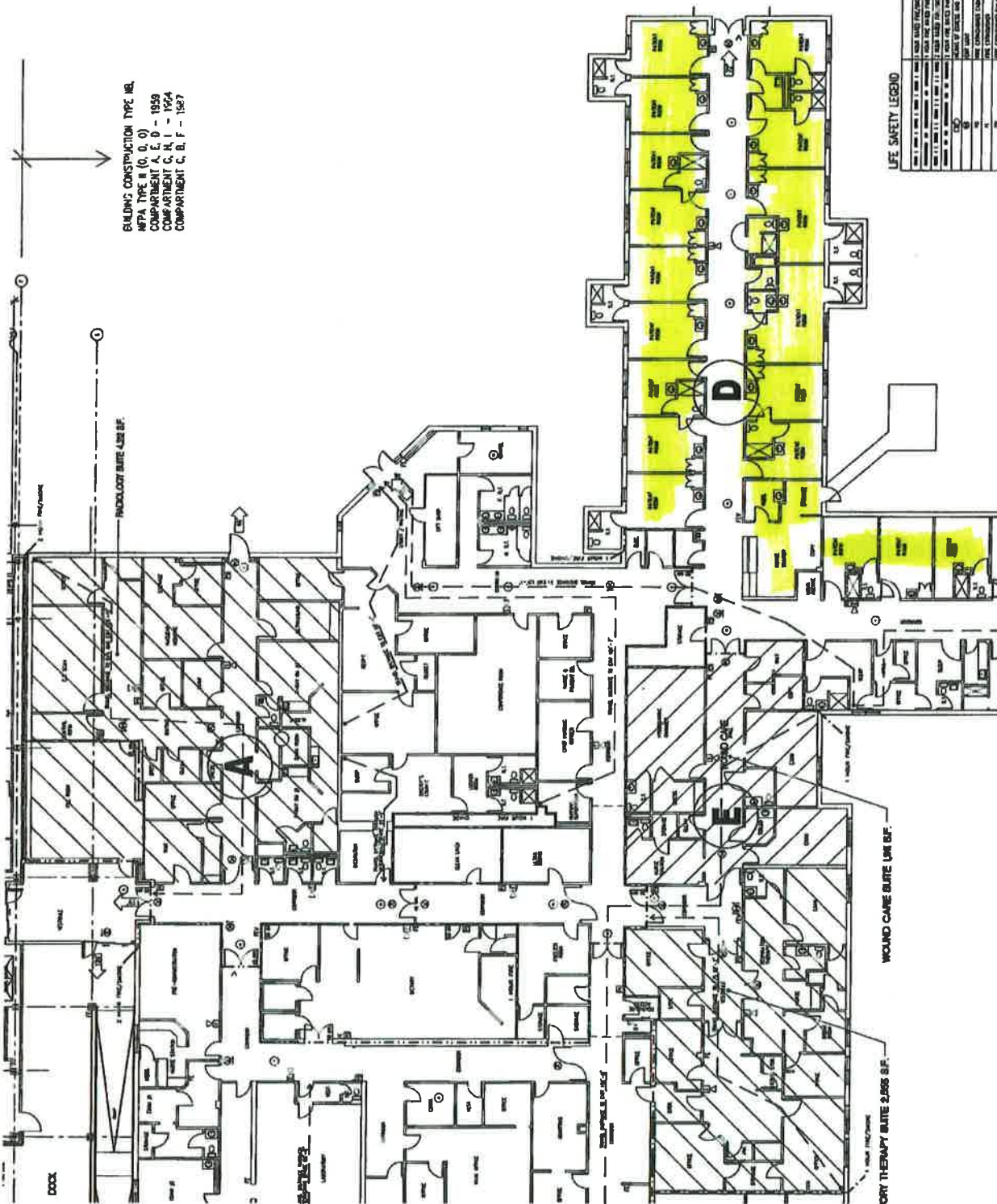
This fact sheet was prepared as a service to the public and is not intended to grant rights or impose obligations. This fact sheet may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Your feedback is important to us and we use your suggestions to help us improve our educational products, services and activities and to develop products, services and activities that better meet your educational needs. To evaluate Medicare Learning Network® (MLN) products, services and activities you have participated in, received, or downloaded, please go to <http://www.cms.gov/MLNProducts> and click on the link called 'MLN Opinion Page' in the left-hand menu and follow the instructions.

Please send your suggestions related to MLN product topics or formats to [MLN@cms.hhs.gov](mailto:MLN@cms.hhs.gov).

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## **Attachment 7**



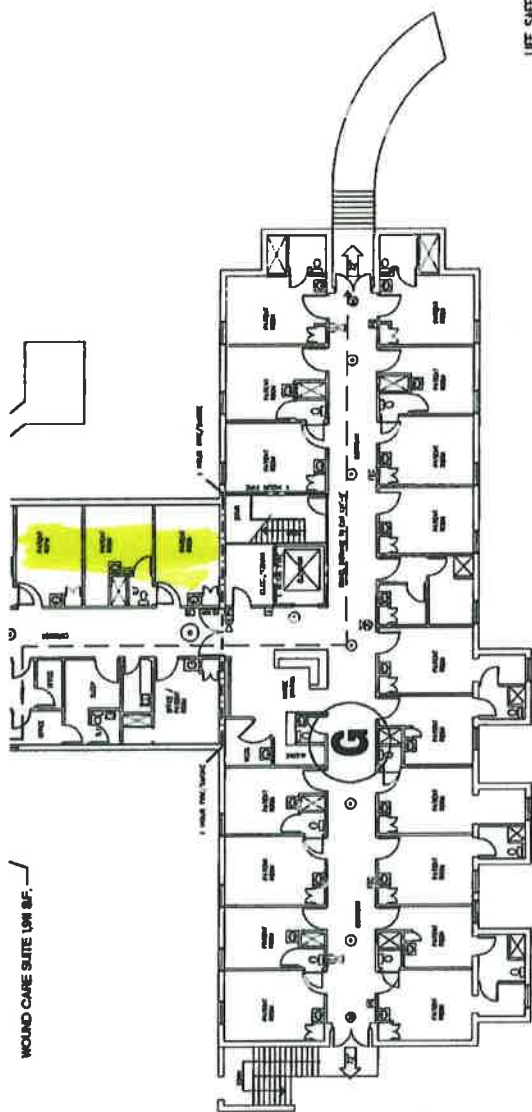
**LIFE SAFETY LEGEND**

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**LIFE SAFETY PLAN  
GROUND LEVEL**

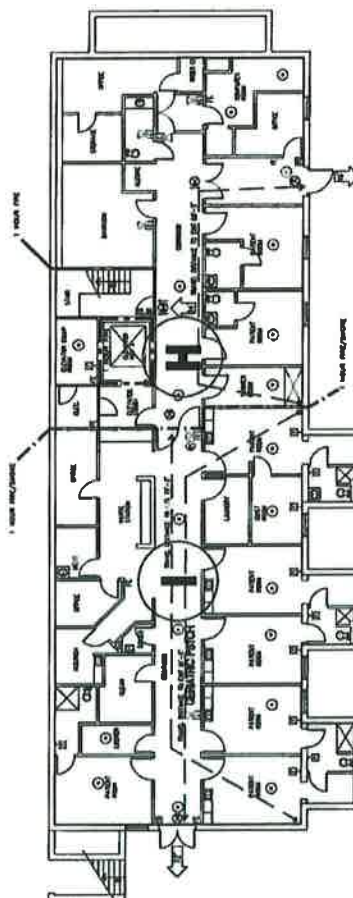
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WOUND CARE SUITE 194 S.F.



**EXISTING GROUND FLOOR**  
SCALE 1/8"=1'-0"

LIFE SAFETY LEGEND	
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**EXISTING LOWER FLOOR**

## **Attachment 11**

**Skilled Nursing Beds in the Jamestown Regional Medical Center Service Area**

Facility	Licensed Beds	SNF Beds - Medicare	SNF/NF Beds - Dually Certified	NF Beds - Medicaid	Licensed Only Beds - Non-Certified	SNF Medicare ADC	SNF Medicaid ADC	SNF All Other Payors ADC	NF ADC	Total ADC
Signature Healthcare of Fentress County	140		100		40	27.2	1.4	0.0	68.3	96.9
Pickett Care and Rehabilitation Center	69		69			16.2	0.5		48.0	64.7
Life Care Center of Morgan County	124		124			11.2	2.9	8.1	73.6	95.8
Huntsville Manor	96		96			18.8	4.4	2.6	63.8	89.5
Oneida Nursing & Rehab Center	56		56			15.8			35.4	51.2
Bethesda Health Care Center	120		120			21.0			90.1	111.1
Masters Health Care Center	175		175			30.8	2.0	0.8	131.8	165.3
NHC Healthcare, Cookeville	94		48	46		23.4	9.8		54.0	87.2
Standing Stone Care & Rehabilitation Center	115		78		37	18.8			73.6	92.4
Life Care Center of Crossville	122		122			24.4			60.8	85.3
Mary Cravath Wharton Nursing Home	62			62					60.9	60.9
Good Samaritan Society Fairfield Glade*	30		30							
WyndRidge Health & Rehabilitation Center	157		157							
All Providers	1,360		1,175	108	77	228	21	12	876	1,137

Source: 2011 Joint Annual Reports

\* Good Samaritan Society Fairfield Glade was implemented in November, 2011. No publicly reported data is available.

Six County Service Area Utilization Trends (2009 - 2011)

Facility	Licensed Beds	2009 Patient Days	2010 Patient Days	2011 Patient Days	09-'11 % Change	2009 % Occupancy	2010 % Occupancy	2011 % Occupancy
Signature Healthcare of Fentress County	140	34,760	34,966	35,385	1.8%	68.0%	68.4%	69.2%
Pickett Care and Rehabilitation Center	69	24,187	23,759	23,631	-2.3%	96.0%	94.3%	93.8%
Life Care Center of Morgan County	124	41,609	38,012	34,978	-15.9%	91.9%	84.0%	77.3%
Huntsville Manor	96	32,502	32,906	32,661	0.5%	92.8%	93.9%	93.2%
Oneida Nursing & Rehab Center	56	18,490	20,204	18,690	1.1%	90.5%	98.8%	91.4%
Bethesda Health Care Center	120	30,080	76,780	40,560	34.8%	68.7%	175.3%	92.6%
Masters Health Care Center	175	61,759	62,601	60,331	-2.3%	96.7%	98.0%	94.5%
NHC Healthcare, Cookeville	94	32,298	32,380	31,823	-1.5%	94.1%	94.4%	92.8%
Standing Stone Care & Rehabilitation Center	115	32,630	31,847	33,724	3.4%	77.7%	75.9%	80.3%
Life Care Center of Crossville	122	38,492	29,279	31,127	-19.1%	86.4%	65.8%	69.9%
Mary Cravath Wharton Nursing Home	62	21,595	22,138	22,241	3.0%	95.4%	97.8%	98.3%
WyndRidge Health & Rehabilitation Center	157	52,339	51,403	49,980	-4.5%	91.3%	89.7%	87.2%
Good Samaritan Society Fairfield Glade	30							
All Providers	1,360	420,741	456,275	415,131	-1.3%	84.8%	91.9%	83.6%

NOTE: 2010 Patient Days for Bethesda Health Care Center appears to be a reporting error in the Joint Annual Report. More days reported than available

Good Samaritan Fairfield Glade was implemented in November 2011. No utilization data is available for 2011

Source: 2009-2011 Joint Annual Reports

**Attachment 14.A**

## HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January (Month).

	Year <u>2009</u>	Year <u>2010</u>	Year <u>2011</u>
A. Utilization Data (Admissions)	<u>2,487</u>	<u>2,307</u>	<u>2,289</u>
B. Revenue from Services to Patients			
1. Inpatient Services	<u>\$35,802,115</u>	<u>\$36,741,393</u>	<u>\$36,922,288</u>
2. Outpatient Services	<u>39,226,632</u>	<u>38,481,703</u>	<u>43,080,887</u>
3. Emergency Services	<u>                    </u>	<u>                    </u>	<u>                    </u>
4. Other Operating Revenue (Specify) <u>Cafeteria, Medical Record Fees, Nursing Student Fees</u>	<u>53,003</u>	<u>42,433</u>	<u>50,269</u>
<b>Gross Operating Revenue</b>	<b><u>\$75,081,750</u></b>	<b><u>\$75,265,529</u></b>	<b><u>\$80,053,444</u></b>
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	<u>\$46,356,633</u>	<u>\$47,140,334</u>	<u>\$49,311,303</u>
2. Provision for Charity Care	<u>7,845,263</u>	<u>8,314,376</u>	<u>9,596,874</u>
3. Provisions for Bad Debt	<u>2,914,185</u>	<u>2,550,841</u>	<u>2,832,644</u>
<b>Total Deductions</b>	<b><u>\$57,116,081</u></b>	<b><u>\$58,005,551</u></b>	<b><u>\$61,740,821</u></b>
<b>NET OPERATING REVENUE</b>	<b><u>\$17,965,669</u></b>	<b><u>\$17,259,978</u></b>	<b><u>\$18,312,623</u></b>
D. Operating Expenses			
1. Salaries and Wages	<u>\$10,039,123</u>	<u>\$9,601,915</u>	<u>\$8,996,114</u>
2. Physician's Salaries and Wages	<u>                    </u>	<u>                    </u>	<u>                    </u>
3. Supplies	<u>1,918,924</u>	<u>1,763,487</u>	<u>1,665,688</u>
4. Taxes	<u>                    </u>	<u>                    </u>	<u>                    </u>
5. Depreciation	<u>1,170,174</u>	<u>1,151,471</u>	<u>1,004,863</u>
6. Rent	<u>271,963</u>	<u>361,715</u>	<u>376,482</u>
7. Interest, other than Capital	<u>46,601</u>	<u>48,663</u>	<u>53,152</u>
8. Management Fees:			
a. Fees to Affiliates	<u>996,989</u>	<u>630,953</u>	<u>1,292,053</u>
b. Fees to Non-Affiliates	<u>                    </u>	<u>                    </u>	<u>                    </u>
9. Other Expenses – Specify on separate page 14	<u>4,160,429</u>	<u>5,380,448</u>	<u>6,216,326</u>
<b>Total Operating Expenses</b>	<b><u>\$18,604,203</u></b>	<b><u>\$18,938,652</u></b>	<b><u>\$19,604,678</u></b>
E. Other Revenue (Expenses) – Net (Specify) _____	<u>\$ _____</u>	<u>\$ _____</u>	<u>\$ _____</u>
<b>NET OPERATING INCOME (LOSS)</b>	<b><u>\$(638,534)</u></b>	<b><u>\$(1,678,674)</u></b>	<b><u>\$(1,292,055)</u></b>
F. Capital Expenditures			
1. Retirement of Principal	<u>\$ _____</u>	<u>\$ _____</u>	<u>\$ _____</u>
2. Interest	<u>                    </u>	<u>                    </u>	<u>                    </u>
<b>Total Capital Expenditures</b>	<b><u>\$ _____</u></b>	<b><u>\$ _____</u></b>	<b><u>\$ _____</u></b>
<b>NET OPERATING INCOME (LOSS)</b>			
<b>LESS CAPITAL EXPENDITURES</b>	<b><u>\$(638,534)</u></b>	<b><u>\$(1,678,674)</u></b>	<b><u>\$(1,292,055)</u></b>

## HISTORICAL DATA CHART-OTHER EXPENSES

**OTHER EXPENSE CATEGORIES:**

	<u>2009</u>	<u>2010</u>	<u>2011</u>
1. Repairs and Maintenance	\$ 506,514	\$ 599,723	\$ 652,005
2. Travel/Mileage	\$ 47,269	\$ 52,759	\$ 68,666
3. Meals	\$ 4,657	\$ 4,803	\$ 4,360
4. Training	\$ 16,789	\$ 29,264	\$ 36,269
5. Dues & Subscriptions	\$ 63,102	\$ 67,521	\$ 71,876
6. Recruitment	\$ 107,747	\$ 34,014	\$ 22,645
7. Insurances	\$1,598,746	\$2,077,797	\$2,741,288
8. Outside Services	<u>\$1,815,605</u>	<u>\$2,514,067</u>	<u>\$2,881,626</u>
<b>Total Other Expenses</b>	<b>\$4,160,429</b>	<b>\$5,380,448</b>	<b>\$6,216,326</b>

**Attachment 14.B**

**PROJECTED DATA CHART**

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

	<b>Year 1</b>	<b>Year 2</b>
A. Utilization Data (Admissions)	<u>2,432</u>	<u>2,505</u>
B. Revenue from Services to Patients		
1. Inpatient Services	<u>\$46,202,000</u>	<u>\$47,588,060</u>
2. Outpatient Services	<u>59,404,000</u>	<u>61,186,120</u>
3. Emergency Services	<u>                    </u>	<u>                    </u>
4. Other Operating Revenue (Specify) <u>                                    </u>	<u>                    </u>	<u>                    </u>
<b>Gross Operating Revenue</b>	<b><u>\$105,606,000</u></b>	<b><u>\$108,774,180</u></b>
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	<u>\$75,424,000</u>	<u>\$77,686,720</u>
2. Provision for Charity Care	<u>3,574,000</u>	<u>3,681,220</u>
3. Provisions for Bad Debt	<u>4,058,000</u>	<u>4,179,740</u>
<b>Total Deductions</b>	<b><u>\$83,056,000</u></b>	<b><u>\$23,226,500</u></b>
<b>NET OPERATING REVENUE</b>	<b><u>\$22,550,000</u></b>	<b><u>\$23,226,500</u></b>
D. Operating Expenses		
1. Salaries and Wages	<u>\$10,295,000</u>	<u>\$10,603,850</u>
2. Physician's Salaries and Wages	<u>20,000</u>	<u>20,600</u>
3. Supplies	<u>2,057,000</u>	<u>2,118,710</u>
4. Taxes	<u>325,000</u>	<u>334,750</u>
5. Depreciation	<u>859,000</u>	<u>884,770</u>
6. Rent	<u>339,000</u>	<u>349,170</u>
7. Interest, other than Capital	<u>                    </u>	<u>                    </u>
8. Management Fees:		
a. Fees to Affiliates	<u>982,000</u>	<u>1,011,460</u>
b. Fees to Non-Affiliates	<u>                    </u>	<u>                    </u>
9. Other Expenses – Specify on separate page 14	<u>6,993,000</u>	<u>7,202,790</u>
<b>Total Operating Expenses</b>	<b><u>\$21,870,000</u></b>	<b><u>\$22,526,100</u></b>
E. Other Revenue (Expenses) -- Net (Specify) <u>                                    </u>	<u>\$                    </u>	<u>\$                    </u>
<b>NET OPERATING INCOME (LOSS)</b>	<b><u>\$680,000</u></b>	<b><u>\$700,400</u></b>
F. Capital Expenditures		
1. Retirement of Principal	<u>\$                    </u>	<u>\$                    </u>
2. Interest	<u>                    </u>	<u>                    </u>

	<b>Total Capital Expenditures</b>	<b>\$ _____</b>	<b>\$ _____</b>
<b>NET OPERATING INCOME (LOSS)</b>			
<b>LESS CAPITAL EXPENDITURES</b>		<b>\$ <u>680,000</u></b>	<b>\$ <u>700,400</u></b>

**PROJECTED DATA CHART-OTHER EXPENSES**

**OTHER EXPENSE CATEGORIES:**

	<u>Year 1</u>	<u>Year 2</u>
1. Repairs and Maintenance	\$ 672,000	\$ 692,160
2. Travel/Mileage	\$ 40,000	\$ 41,200
3. Meals	\$ 3,000	\$ 3,090
4. Training	\$ 29,000	\$ 29,870
5. Dues & Subscriptions	\$ 160,000	\$ 164,800
6. Recruitment	\$ 26,000	\$ 26,780
8. Advertising	\$ 50,000	\$ 51,500
9. Postage	\$ 17,000	\$ 17,510
10. Telephone	\$ 79,000	\$ 81,370
11. Utilities	\$ 387,000	\$ 398,610
7. Insurances	\$1,962,000	\$2,020,860
8. Outside Services	<u>\$3,568,000</u>	<u>\$3,675,040</u>
<b>Total Other Expenses</b>	<b>\$6,993,000</b>	<b>\$7,202,790</b>

**Attachment 18**

## PROJECT COMPLETION FORECAST CHART

February 27, 2013 T.C.A. § 68-11-1609(c): \_\_\_\_\_

Assuming the CON approval becomes the final agency action on that date; indicate the number of days from the above agency decision date to each phase of the completion forecast.

<b>Phase</b>	<b><u>DAYS REQUIRED</u></b>	<b><u>Anticipated Date</u> (MONTH/YEAR)</b>
1. Architectural and engineering contract signed		
2. Construction documents approved by the Tennessee Department of Health		
3. Construction contract signed		
4. Building permit secured		
5. Site preparation completed		
6. Building construction commenced		
7. Construction 40% complete		
8. Construction 80% complete		
9. Construction 100% complete (approved for occupancy)		
10. *Issuance of license	45 days	April, 2013
11. *Initiation of service	1 day	April, 2013
12. Final Architectural Certification of Payment		
13. Final Project Report Form (HF0055)		

**\* For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

**Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.**